

# **Male Involvement in Family Planning: Experiences from Innovative Projects**

**1997**

Population Council, Bangladesh  
Bangladesh Directorate of Family Planning  
NIPORT

## **INTRODUCTION AND OBJECTIVES:**

The workshop on 'Male Involvement in Family Planning: Experiences from Innovative Projects' was organized by Population Council in collaboration with the Directorate of Family Planning and NIPOORT. This participatory workshop was held in Rajendrapur, Dhaka, on August 7, 1997 and was attended by 49 representatives of the Government, NGOs and donor agencies.

The purpose of the workshop was to share the experience from the innovative projects experimenting with male involvement in family planning programs. The workshop had three main objectives: 1) to share findings from three innovative projects; 2) to generate discussion among key program personnel in government and non-government agencies regarding the program implication of the study findings; and 3) to develop specific recommendations regarding enhanced male participation in the program activities.

## **IMPLEMENTATION OF THE WORKSHOP :**

The opening ceremony was chaired by the Director General, Directorate of Family Planning. Dr. Ubaidur Rob, Resident Advisor, Population Council presented the objectives and the agenda of the workshop. He briefly discussed the three operational research projects in which the interventions were tested. Dr. Rob indicated that in those projects, orientation and training of field workers, development and dissemination of IEC materials, introduction of special services of men and involvement of community leaders can improve male involvement in family planning.

Ms. Nancy J Piet Pelon, Consultant, Population Council stressed the need to publicize services and male contraceptives. Messages on how men can benefit from using methods and how using FP methods can enhance their esteem. She also emphasised the need to train male service providers so that they could properly counsel men. Satisfied male users could also be enlisted to promote male oriented methods and to counsel other men. Ms. Piet Pelon sighted that service centers need to be reorganized to cater the needs of men so that they may obtain what they want, when they want.

Mr. David Piet, Director, OPH, USAID, while giving his speech, elucidated some of the planned contributions of NIPHP on male involvement. He also stated that men should and must be involved in the health and well-being of their communities and their families more actively than their current situation. He asked for options to implement change in the current scenario and called for sustainability of family health services. Mr. Piet suggested that the supportive systems as well as quality of information be improved, services and products must cater to the needs of the customer.

In his speech the Director General, Directorate of Family Planning, Mr. Shirajul Islam stressed reactivating the motivational efforts towards males by re-designing program approaches. He also called for developing operational policy guidelines in order to reformulate the program strategies. He suggested that more experimental research projects should be implemented to evolve appropriate program strategies directed towards effective involvement of males in the FP program. IEC materials for male

motivation should be properly designed and these should highlight the role and responsibility of parenthood.

The **business session** of the workshop was divided into two parts: **(i) Paper presentation**, and **(ii) Group discussion**. The following five papers were presented in the workshop:

- \* Male Motivation Program for Promoting Reproductive Health In Bangladesh: Senbug Experiences.
- \* Male Participation, A Key to Future FP Program Success: Sonargaon Experiences.
- \* A Male Intervention Project: Kalihati Experiences.
- \* Newlywed Couples: Role of Husbands in Use of Family Planning
- \* Male Involvement in Family Planning: Experiences From AVSC Activities/Projects

## **RECOMMENDATIONS OF THE WORKSHOP**

The focus of the workshop were the five presentations of experimental programs in Senbug, Sonargaon and Kalihati thanas and the program managers perspectives on the potential to increase the use of clinical methods and innovative approaches to newlywed couples. Each innovative approach engendered lively discussion and keen questioning from the participants. All were concerned that attention to mens' services should not be directed to upset the great gains which have been made in women's' participation, particularly acceptance of female methods. Thus, attention was given to the practical aspects of these new programs and their management using existing personnel and infrastructure.

The recommendations made by the participants reflect their concerns with two programmatic elements: i) any program needs to be practical and implementable, as much as possible, with the existing manpower and infrastructure; and ii) the innovative programs which have been started need to complete their experimentation.

### **Priority Recommendations**

- 1) As the question of male involvement is critical, immediate expansion of the experimental programs is recommended. A combination of the Sonargaon and Kalihati programs is an appropriate model to replicate, taking the most effective elements of each. The Sonargaon experiment has undertaken innovative work with IEC which should be incorporated into the Kalihati model which has made the most effective use of the Government infrastructure. This combined program should be planned for ten thanas and finalized for immediate implementation by the Directorate of Family Planning.

In both Kalihati and Sonargoan projects, husbands have been given special times to visit the H & FWC. This has been an effective experiment and should be replicated. Men should have special, scheduled hours for information and services.

An image "remake" of the H & FWC, FWCs, and Satellite Clinics is recommended. Now these are considered as "women and children centers". There is a need to "advertise" these as centers where men can also receive services. The concept of "one-stop shopping", as defined in HPSS, is part of this revised image.

- 2) Both the Sonargoan and Kalihati programs have developed experimental and inexpensive IEC materials for use by both service providers and men. These materials should be made available to all male involvement programs for immediate use. At the end of six months, based on the expanded field use, these can be finalized and replicated for national distribution.
- 3) All workers -- community-based, clinical, and administrative -- require orientation about male involvement. Particular attention at these orientations can be on the Kalihati project which re-oriented FWAs to counsel couples who had been long-term acceptors on temporary methods to consider vasectomy as an option. However, care must be taken in orientation to ensure that the role of men is not too narrowly defined. Men can participate and be supportive in many ways other than being vasectomy acceptors.
- 4) FWAs, as well as the community workers from NGOs, should be encouraged to systematically identify and register newlyweds. All newlyweds should be considered as eligible for family planning and need visits by the field worker, as done in the Pathfinder project areas.
- 5) A campaign style week targeting men for information and services may be considered (similar to the Family Planning Fortnight).

The general consensus from the 49 participants was that the experimental programs were encouraging. The results, though preliminary, clearly showed that approaches to men are possible and can achieve desired objectives.

**WORKSHOP ON  
MALE INVOLVEMENT IN FAMILY PLANNING  
Experience from Innovative Projects  
7 August, 1997  
Rajendrapur, Dhaka**

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<b>Program</b>	
<b>Time</b>	<b>Topics</b>
<b>09:00 - 09:30</b>	<b>Registration of Participants</b>
<b>09:30 - 10:30</b>	<b>Opening Session</b>
09:30 - 09:45	Objectives of the Workshop Ubaidur Rob
09:45-10:00	Overview of Male Involvement in Bangladesh Nancy J. Piet-Pelon
10:00-10:15	NIPHP and Male Involvement David L. Piet
10:15-10:30	Speech by Director General, Family Planning
<b>10:30 - 11:00</b>	<b>Tea Break</b>
<b>11:00 - 13:00</b>	<b>Experience from the Field</b>
<b>Chairperson: Director General, Family Planning</b>	
11:00 - 11:20	Male Motivation Program for Promoting Reproductive Health in Bangladesh: Senbug Experiences Ahmed Neaz, Hasina Banu, Jahangeer Alam
11:20 - 11:40	Male Participation: A Key to Future FP Program Success: Sonargaon Experiences Md. Najmul Huq
11:40 - 12:00	A Male Intervention Project: Kalihati Experiences: An Interim Report M. Nawab Ali, Ahmed Al-Sabir, Ubaidur Rob, Nancy Piet Pelon
12:00 - 13:00	Open Discussions

**WORKSHOP ON  
MALE INVOLVEMENT IN FAMILY PLANNING  
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**13:00 - 14:00**

**Prayer and Lunch Break**

**14:00-15:00**

**Program Managers' Perspective**

**Chairperson: Executive Director, CWFP**

14:00-14:20

Newlywed Couples: Role of Husbands in the Use  
of Family Planning  
M. Alauddin

14:20-14:40

Male Involvement in Family Planning: Experiences  
from AVSC Activities/Projects  
Moslehuddin Ahmed, A.J. Faisel, Jafar Ahmed  
Hakim

**14:40-15:00**

**Open Discussion**

**15:00-16:00**

**Future Strategies**

**Chairperson: Director General, NIPORT**

**15:00 -16:25**

**Group Discussions & Presentation of Recommendations**

**16:25-16:30**

**Vote of thanks**

**16:30-17:00**

**Tea**

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## **LIST OF PARTICIPANTS**

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## ***Objectives of the Workshop***

**Dr. Ubaidur Rob  
Resident Advisor  
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Mr. Shirajul Islam, Director General, Directorate of Family Planning; Mr. David Piet, Director, OPH, USAID, Dhaka and learned participants:

Today we are here to discuss topic which has been an issue ever since the organized Family Planning Program started in Bangladesh. In the early years of the National Family Planning Program, the male participation role was limited but noticeable. Men accepted Vasectomy in large numbers and approximately 400000 Vasectomies were performed in 1969. However, starting from the mid Eighties, the acceptance of women's methods increased significantly while the acceptance of male method has declined.

Despite the success of Family Planning Programs, the contraceptive acceptance rates remain low among several subgroups of population, particularly among males. The full range of modern family planning methods still remains unavailable to approximately ten million couples-----many of whom say that they want to space or prevent another pregnancy.

At the National Workshop on 'Male Involvement in Family Planning', the Secretary, Ministry of Health and Family Welfare called upon the participants to immediately translate rhetoric into action. Responding to his request Population Council and CIDA provided technical and financial assistance to implement three Operations Research projects on this topic. The interventions tested in these projects are described below.

Kalihati thana's Program of Male Involvement : The Directorate of Family Planning with technical assistance from NIPORT and Population Council is implementing an Operations Research project involving men in rural Bangladesh. The interventions include : (I) orientation and training of the front-line workers and service providers on all aspects of male programs and services, as well as orientation for NGO and multi-sectoral field workers regarding male services; (ii) development and dissemination of IEC materials for service providers and for men and their partners to contracepting women; and (iii) introduction of special services from men which include provision of NSV at thana Health Complexes and upgraded FWCs and exclusive clinic hours for men to receive information or services. During it's initial phase of implementation with new programmatic interventions, a large number of men expressed their interest about male methods. The project has developed a strong realization among service providers at the field level about the importance of male involvement in reproductive health activities.

A Male Motivation Program for Promoting Family Planning : A local NGO with financial assistance from CIDA initiated an intervention project to establish a working mechanism to increase contract between male FP workers and male clients in rural areas. The primary objective of the project is to encourage male supervisors (FPIs) to motivate male clients on regular basis. Findings suggest that FPIs are not performing their role as male motivators.

Community Involvement Project, Sonargaon : Community leaders and family planning workers are involved in motivational activities to inform men about their role and responsibilities regarding family planning. The project is being implemented by CPD.

The overall objective of the workshop is to share experiences from the innovative projects experimenting with male involvement in family planning and design future strategies to increase male participation in the program activities.

The future demographic scenario of the country will be determined in the next two decades. Depending on how faster the country reaches to Replacement Level of Fertility, the total population size will be between 250 and 400 million in 2050. We have to act now, and also as quickly as possible to bring males in the program activities.

***Male Involvement in the Bangladesh  
Family Planning & Reproductive Health Program***

**Nancy J. Piet-Pelon  
Consultant  
Population Council, Dhaka, Bangladesh**

The Bangladesh national family planning program is focused on two aspects of involving men. First is their direct responsibilities in family planning and second their influence on the reproductive health status of their partners. There are two cautions which Bangladesh must observe because of the nature of its family planning service delivery program and the cultural constructs which undergrid it. First, particular care must be taken not define men's reproductive health roles too narrowly. Having men as active family planning users or supportive partners is one -- but only one -- of their roles. Since the national goal is a positive impact on the reproductive health status of women through male involvement, it is essential that men take an active responsibility in all aspects of reproductive health -- both their own and their partners. Second, and particularly important to the Bangladesh family planning program, it is critical to balance what is expected from men with the gains that women have already made. When men are encouraged to take "active roles", they cannot be allowed to encroach on women's rights to make their own decisions and be "in charge" of their own bodies.

## **FAMILY PLANNING**

Men and their involvement in family planning and reproductive health has been quite a popular topic since ICPD in 1994. Countries, after helping to define a broader role for men, have since grappled with trying to implement programs.

How does Bangladesh do what ICPD's Program of Action suggests? How does it **"...encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles?"** How does it **"...emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning...?"**

A facile response is -- "not easily". Why not?

In the first place, men are already involved in family planning and have been for centuries. Their involvement has changed throughout the years. Prior to the advent of hormonal methods less than 50 years ago, men have shared some part in birth control. The choices were very limited. Most couples did not have the means to directly control fertility so they controlled births by abortion. However, withdrawal was used and required that men be responsible. About 400 years, condoms were developed though

their use for birth control was not their primary use. These were developed for the prevention of venereal diseases -- also known as the diseases of love. When the relationship between ovulation and pregnancy was finally discovered in the 1930s, men participated in family planning as consenting partners to periodic abstinence or the use of the safe period.

Compared to these difficult to use and, relatively ineffective methods, vasectomy stands out. First discovered around the turn of the century, vasectomies were introduced in Bangladesh during Pakistan times. This method was accepted by approximately one million men between 1965-70.

With the advent of hormonal and intrauterine methods, men's roles have changed dramatically. Instead of being forced to be direct users of either a marginally effective or permanent method, men could do take one of four actions: i) they could support the use of methods by their wives; ii) they could also deny the use if they wished; iii) they could continue to be users themselves; or iv) they could abdicate responsibility from the entire process.

Bangladesh has made significant progress in family planning since the inception of the national program. The results of the BDHS of 1996-97 show a clear and continued increase in contraceptive use. There is a reported CPR of 49.2 percent and a TFR of 3.3. Certainly the program is getting to where it wants to be -- but it is not there yet.

The principal questions the program is asking itself are:

- Would getting men more involved make a difference?  
If yes, how can it be done?

Understanding where the program needs to go, depends on the past and the present. The proportional use of methods that men use directly -- condom or vasectomy -- or participate in -- periodic abstinence or withdrawal -- has changed since the inception of the program (illustrated on the following graph).

It is clear that the proportional use of male methods has decreased while CPR has steadily risen. Why is this so? We will seek an answer to this elusive question using a process of elimination.

### ***Essential Question Regarding Men and Family Planning***

Is this proportional change because men do not have information about family planning methods?

No. When researchers ask men the simple questions about family planning, they give the "right" answers. At least 90 percent of them can name modern methods and also sources of supply. Some men take responsibility for obtaining methods, particularly oral pills and condoms, from commercial sources.

If men have information about methods and source of supply, is it their attitude which prevents them from being active users?

No. Men have positive attitudes about family planning. Regardless of residence, education or age, the vast majority of men approve of family planning. Even in Chittagong where acceptance lags, 85 percent of men approve of family planning.

Do men agree with their wives about family planning?

Yes. In Bangladesh, men know what their wives believe about family planning and in 97 percent of case, there is mutual agreement. Men also agree with the small family norm. Two-thirds of men who have two children say they do not want more children.

Based on this evidence, the Bangladesh Demographic and Health Survey in 1993-94 concludes that husbands are not more pro-natalist than their wives. There is no reason to assume that these attitudes will change.

It is clear that when men are asked simple questions about family planning, they give the right answers -- or the ones program managers would like to hear. What about in depth knowledge?

One of the long-standing problems of the Bangladesh program are the high discontinuation rates of all methods. There has been no improvement in discontinuation rates between the 1993-94 and 1996-97 BDHS. Half the users stop using their methods in the first year.

Do men have anything to do with this?

At face value, no. Only 7 percent of women say they stop contracepting because of a husband's disapproval. However, two areas need further elucidation. Women drop out of modern method use primarily because of side effects. Do husbands exacerbate this drop out rate? No one knows the answer to this question but it certainly requires one. In supportive partnership, men facilitate treatment for the side effects their wives experience. It does not look like this is happening.

Second, what about discontinuation of male participation methods. What are the most important reasons for not continuing to use these methods? As the following table shows, the disapproval of husbands has a much stronger influence on the discontinuation of methods which require their direct participation.

It appears that men take a much more active role in disapproving when they are inconvenienced.

What about reasons for non-use?

Women over 30 rarely mention their husband's disapproval directly -- only 5 percent. Husband's disapproval is a bit more compelling for younger women -- 14 percent.

What about future method use? Are men planning on taking an active part later?

Available evidence indicates they will not take a more active role as the table below illustrates. Caution should be used here, however, as this question is asked to women. Clearly, women do not expect much from men in terms of future use.

Decision-making is a delicate aspect of family planning use. Here is where the balance of "rights" needs to be maintained. The program has to ensure that women have the opportunity to make good decisions -- independently -- or jointly. Men should not be allowed to take over decision-making or dictating. Yet, the program would like them to participate.

In Bangladesh currently couples make joint decisions for family planning use in about 41 percent of all cases. An additional 30 percent of women say they had the greatest influence. Twenty-two percent say their husbands were more influential. These figures indicate that men do not dominate the decision though the response does vary with age. As expected, younger women state their husband has more influence than older women do.

### **How to summarize this information?**

Men are reasonably positive about family planning though there are some areas where there is still not enough information or where one is left to wonder about male influence. Basically, however, if the characteristics of this group are listed -- without ascribing gender -- most observers would assume that the described would be family planning acceptors. So, why aren't they?

### ***Men and Methods in Bangladesh***

Two factors influence men in Bangladesh. First, male methods are singularly unattractive. Vasectomy is for a select group of men who are ready for a permanent method. Condom use is disparaged for aesthetic reasons. It is a frustrating method -- embarrassing to obtain, difficult to store, clumsy to use, and a nuisance to dispose.

Periodic abstinence and withdrawal are even more difficult methods to use consistently. These require excellent spousal communication, discipline and an understanding that method failure is high. For withdrawal, the first year failure rate is 18 percent for typical users. In Bangladesh the rate is almost 20 percent. Periodic abstinence has a 20 percent first year failure rate. Condoms can also have a high failure rate, 12 percent in the first year of use. So, the methods are not attractive.

Second is the problem of access to both services and in-depth information. The Bangladesh program does not provide information on traditional methods. A recent study of traditional method use (Gray et al., 1997) found that only 25 percent of men who were current users of periodic abstinence had correct information about its use.

Condoms are the most accessible of all male methods. These are widely available through 150,000 outlets supplied through the social marketing program (SMC), as well as community-based workers who provide methods at the household.

Vasectomy is less accessible than it was in the past -- and the numbers reflect that change.

Vasectomy services have had a checkered history in Bangladesh. In the early days of the program, vasectomies were widely available. Men were contacted through program workers or self-appointed agents, compensations were provided to clients and referral fees to agents. All program workers had targets which had to be met or punitive measures could be taken. Using these combined means, sterilization performance rose steadily, peaking in 1984-85 with over 200,000 procedures. However, concerns about quality and client rights forced the national program to change its approach. The numbers show what has happened since all referral fees have been removed in the program in 1987 -- though the downward trend was perceptible before that.

Even the introduction of non-scalpel vasectomy (NSV) in 1989 NSV did not stem the downward trend. In other countries the introduction of NSV has caused a dramatic rise in performance. Why not in Bangladesh? Frankly, it is the only method in Bangladesh's family planning program that was introduced without an accompanying IEC promotion. So clients did not know about the new method. Also, many of the service providers have not been trained in the technique. This is particularly ironic. Bangladesh has the premiere vasectomy providers in the world. Service providers come from other countries to learn NSV in Bangladesh. Yet, Bangladesh has not trained all its own potential providers.

Consequently, NSV is inaccessible to most men who might want to want it -- or at least learn more about it. In the clinical method situation analysis completed (Barkat et al., 1994) only 22 percent of Model Clinics and 5 percent of THCs had NSV services. Even conventional or incisional vasectomy was provided in only 68 percent of THCs. Information about the method was not provided in any of the client provider interactions which were observed.

Why is the lack of accessibility of vasectomy so important? One group of women could particularly benefit if their partners were vasectomized. appropriate. As the graph below shows, a large portion of women who are over 30 years of age are either not using a method or are using less effective traditional methods. Pregnancies in this age group in Bangladesh tend to be highly unwanted since most of these women married as adolescents, completed family size early and now have children at or approaching puberty.

The women on "re-supply methods", mainly oral pills and injectables, are not at risk of pregnancy. However, they too could have an enhanced health status if their husbands' would chose vasectomy since many have used the hormonal methods for five years or more.

A particularly vulnerable group of women, in terms of reproductive health risk, are the married adolescents. Pregnancies are not highly unwanted, as they are for the older group, but are highly risky. There is no analysis of mortality by age in recent maternal mortality figures for women in Bangladesh.

However, a recent national study (Akhter et al. 1996) found that the relative risk of morbidity is highest in women under 18 -- even higher than women over 34 years of age.

A study of traditional family planning (Gray et al. 1997) found an interest in preventing births in this young age group but a genuine fear of the effect of hormonal methods on fertility. Obviously this is an age group where husbands can take a more active role by using condoms or traditional methods to delay the first birth. This is also the age group where women have less autonomy so men need to take a lead if births are to be delayed. This is still a large group of women in Bangladesh since about half the adolescents are married and have their first child before the age of 20 (Streatfield et al. 1994).

There is one final group whose health could be enhanced if husbands would use condoms. This group are women who have recently given birth. Though modern contraceptive methods are not contraindicated for them, allowing extra time to recover from the trauma of child birth prior to accepting a hormonal method or an IUD would enhance their health.

## **REPRODUCTIVE HEALTH**

What about other aspects of reproductive health? There are three principal areas which have been identified for reproductive health services in Bangladesh. Following family planning, these are:

- maternal care or safe motherhood
- prevention of unsafe abortion
- information and services for RTIs, STDs, HIV/AIDS

If the Government is to reach its goal of reducing maternal mortality, the services which will have to change to include men are in all aspects of essential obstetric care and pregnancy termination.

Pregnancy and childbirth is in the women's world in Bangladesh and there are indications that women like to keep it that way. The principal reason that women give for not attending antenatal care, for example, is not because their husband does not allow. Rather it is because they do not believe that anything is wrong (Akhter et al. 1996; Goodburn et al. 1994). Health education needs to be directed at both men and women -- not to engender fear that something is wrong but to encourage practices (like antenatal care and tetanus toxoid immunizations) for the safest and happiest outcome.

Education also has to be provided on planning ahead for the delivery and recognizing danger signs. Men do not have enough information to make good decisions now and, consequently, when called upon to act quickly in an obstetric emergency are unable to do so. Changing behavior in Bangladesh regarding childbirth is a formidable task. Today less than one-third of women have any access to antenatal care and only 8 percent have medically assisted delivery. The vast majority deliver at home with the assistance of a relative (BDHS 1996-97). There are several programs dedicated to the

development of essential and emergency obstetric care in the country. But even after considerable investment and about five years of work less than 25 fully functional new facilities are operational to augment the traditional services which have been provided in major hospitals. Consequently, maternal mortality is still estimated at approximately 5 per 1000 live births.

This is an area where it is essential to maintain a "balance" in messages. The services are not ready for all women to deliver in institutions -- these may never be. The messages have to continue to stress the naturalness of the process of childbirth -- while encouraging the safe guards which ensure a positive outcome: comprehensive antenatal care; a trained birth attendant; preparedness for emergency.

When a pregnancy is unwanted or mis-timed, small (mainly anthropological) recent studies (Ahmed et al, 1997; Caldwell et al., 1997, Hossain et al. 1997) indicate that men are involved in decision making. In about 40 percent of cases, couples make the decision to terminate. Men are active in seeking care and in paying the costs. Unfortunately, both men and women seem to see little difference between the safety of menstrual regulation (MR)<sup>1</sup> or a traditional abortion. Consequently, they make a decision which is potentially very unsafe and can lead to severe morbidity or mortalities.

The other elements of reproductive health are also important, particularly RTIs which are sexually transmitted. There is just the beginning of understanding the breadth and depth of the problem in Bangladesh. Recent studies indicate that men do engage in high risk sexual behavior, often starting at an early age (Chowdhury et al. 1997). Few have any idea of the effect this behavior could have on their future plans for marriage and family formation.

## CONCLUSION

It is clear that men have to become more involved in reproductive health in Bangladesh. Through their active participation in family planning, both as direct users for women in special groups and as supportive partners, men can enhance the reproductive health of their wives.

For men to reach the plain of involvement that is required, programs have to direct their efforts at two areas. The first is education. The Bangladesh program cannot expect men to make good decisions when they have no information. Thus, any program has to be heavy on health education which is delivered through appropriate channels for men.

Men who are program managers and service providers need to actively participate in planning for men's' services. A worldwide impact was made the quality of women's' services when women themselves raised their voices and began to demand improved services. Men have to do the same. Several elements are essential for men's' services.

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*Menstrual regulation services have been available in Bangladesh since the mid-seventies. These can be provided up to 8 weeks following a missed menstruation by a paramedic and to 10 weeks by a physician. MR services are available from Government service points, even at the primary health care level.*

- **Services and male contraceptives need to be well publicized. Publicity should address men's needs and desires. Messages should emphasize how men will benefit from using methods and how using family planning can enhance their esteem.**

**All available opportunities should be utilized at any health and family planning service center to counsel men on their reproductive responsibilities and use of contraceptive methods.**

**Male service providers should be trained to counsel men.**

**Satisfied users can be enlisted to promote male-oriented methods and to counsel other men.**

**Service sites need to be set up to cater to the needs of men. Men should be able to obtain the services they want, when they want.**

**Services for men should respect individual privacy as much as is done for women.**

## ***THE NIPHP PERSPECTIVE ON MALE INVOLVEMENT***

**David L. Piet,  
Director,  
Office of Population and Health,  
USAID in Bangladesh**

I am a man ... and I am involved. I also have a name, a career and social/cultural context in which helps to define how I have to manage my life. All of the other men in the room, my friends and colleagues, are similarly placed. Thus, it is both an honor and a challenge for me to consider the importance of male involvement with you this morning. I suggest that we all suspend for a moment the term "male" as a distant concept and hold in our minds the image of our brothers, friends, nephews or acquaintances.

Today's workshop is focused on male involvement in family planning. However, I would like to take a few moments to place men in a wider cultural and programmatic context of Bangladesh. USAID is principally concerned with poverty alleviation. It is the foundation for all of our development assistance. We define our customers as the poor and disadvantaged of the country. I'd like to read from the conclusions of a recent USAID poverty appraisal.

"The poor see poverty from the perspective of the family, as opposed to focusing on the individual, community or national level. For them, poverty is a multi-dimensional problem, i.e. each person defines poverty in many ways, rather than just one way. Our customers agree that poverty means that **their income is not sufficient to meet their most basic needs** -- living from hand to mouth, but it also means not having land, education, enough food, decent clothing, minimal housing, sanitation, and pure water. **Having too large a family and suffering poor health are other dimensions of poverty.**

The respondents widely agreed on the causes of poverty, including being born into poverty, receiving little or no inheritance, the fragmentation of family land through past inheritances, illness or death of the income earner(s) or the poor health of other family members leading to income loss through inability to work and income erosion through incurring the cost of medical treatment, large families, too many daughters (i.e., the cost of dowries), lack of education, lack of job opportunities, low wages for women, exploitation by the rich, old age, and, of course, natural disasters. In addition, some female respondents mentioned lazy, drunk, drug addicted, and/or gambling husbands. Some wives noted that the male members of the household do not take sufficient responsibility for the welfare of the family; this was, not surprisingly, rarely mentioned by the men."

Under NIPHP, and as a major contributor to USAID's goal of poverty alleviation, we framed together, in this very room October, our NIPHP Results Framework. NIPHP has a single Strategic Objective: "Fertility reduced and family health improved". This strategic objective fits the HPSS and its Essential Package of Services (ESP). HPSS is the national programmatic philosophy and framework. The NIPHP strategic objective is bolstered by five Intermediate Results.

- 1) Use of high impact family health services increased.
- 2) Capabilities of individuals, families and communities to protect and provide for their own health improved.
- 3) Quality of information, services, and products assured and customer satisfaction improved.
- 4) Local service delivery organizations strengthened and associated support systems for high impact family health services improved.
- 5) Sustainability of family health services and support systems improved.

At the implementation level, the central focus of NIPHP is on service delivery and IEC. The foundation for service delivery, both under HPSS, which binds all development partners together to achieve **national** goals and objectives **and** NIPHP is the Essential Package of Services (ESP). There are some 24 elements or interventions. NIPHP includes 18 of the 24.

NIPHP's service package is divided into six categories, each with a number of interventions. For example the reproductive health package includes services for women and men; clinical contraception and pregnancy and delivery care. Child health includes immunizations, Vitamin A delivery and other elements. Limited care for common diseases and first aid are also part of the services.

My theme this morning is that men should and must be involved in the health and well-being of their communities and their families in a much broader way than they currently are. Like the normative change for women which has transformed Bangladesh in ways thought unimaginable ten years ago, the same kind of revolution in thinking must happen for men.

Today's presenters will, I am sure, provide us with some of the options to foment change. They will also provide some new directions from their program efforts as we collectively seek opportunities to further involve men -- our brothers, nephews, cousins, friends and ourselves -- in the future health and well-being of Bangladesh.

**Male Involvement in  
Bangladesh Family Planning Program**

**Mr. Md. Shirajul Islam  
Director General  
FAMILY PLANNING.**

Mr. Chairperson, Special Guest, Mr. David L. Piet, Director, OPH, USAID, Ms. Nancy Piet-Pelon, Dr. Ubaidur Rob of Population Council, distinguished participants, ladies and gentlemen.

It is my great pleasure to be with you to participate in this one-day workshop on Male Involvement in Family Planning, a new challenge to the family planning program. I extend my thanks to the Population Council for inviting me as the Chief Guest in the inaugural session and also to chair a business session. I hope, your deliberations in the workshop will help develop appropriate strategies for effective involvement of men in family planning.

Male involvement in family planning program is being considered as one of the critical areas and has drawn increasing attention from the policy makers and program managers. Recent data on male participation methods indicate that widespread indifference of the male partners of the couples to practice family planning methods might be one of the major explanations for a high level of unmet needs.

The present emphasis on participation of men in family planning can not be viewed as a new program area. Rather, it is a new program emphasis and a renewed perspective on and concern about men. This concern relates to strengthening mutual support amongst the couples in the reproductive health equation in general and promotion of family planning acceptance in particular.

If we look back to the implementation of FP program upto the mid-seventies, participation of males, especially in terms of method acceptance, was much more than that of the females. During the last decade, the situation has been reversed, where the female participation methods are 90% of all method-users. The natural question is, why did it happen so? Is it due to a change in the program policy or a shift of the program emphasis in terms of motivational efforts on methods acceptance according to program perspective based on female orientation and motivational convenience of the service providers. The male involvement in family planning has been a topic of interest for a couple of years. But nothing specific, in terms of programmatic measures or otherwise, has been developed and implemented to improve the situation. I congratulate Population Council and CIDA for providing technical and financial assistance for such programs and I am optimistic about this endeavor.

Till mid-seventies, male approach was the main thrust in the motivational efforts by the male workers and agents. As a result, male method-use got the prominence over the female methods. But with the deployment of a large number of female workers (FWAs) at the community level in the early eighties, the education-motivation efforts were redirected towards approaching the female partners of the couples. The female field workers found the female clients easily and mostly available at home and also felt comfortable to discussing family planning and explaining use of its methods with females freely. This has resulted in much scale practice of female methods now. The importance of male approach towards their participation as contraceptive users and their supportive partnership to contracepting women has thus been overlooked.

Certain factors interplay in preventing men from assuming the responsibility to use male methods, even when they approve and support spacing and limiting the family size. One of these is the least contacts with males by the female field workers. As a result, male partners of the couples are not fully aware of complete information on FP. or well educated on the use and side-effects of different contraceptive methods and what to do if complications arise on method use. There are also rumors and misinformation about male methods.

The family planning field workers have not been able yet to create a conducive environment to develop interspousal communication which can play a major role in increasing male participation in FP. Future efforts to promote fertility regulation need to consider ways to counsel couples together and encourage interspousal communication in decision-making for family planning acceptance.

Females themselves are reported to be the discouraging partners in the use of male methods because of misconception of male methods, apathy towards male partners and fear of social problems to be created by males.

Social legitimization for family planning has not yet been established expectedly within the male population in the community. As a result, they are still hesitant to be exposed to discussing FP with other peer groups and also using methods of contraception. This has, to some extent, restricted the scope for the wide-spread diffusion of effective family planning messages and ultimately led to the limited use of male methods specially.

It is, therefore, evident that males are not left out, rather have become the missing links from the family planning program with the change of education-motivation emphasis redirected towards female orientation. Moreover, family planning program have had little to offer men in terms of contraceptive methods. What is needed now is to re-emphasize the needs for more active participation of men in family planning, to put across renewed efforts to create new demands for information and services for men with specially designed IEC materials. I like to place before you the following suggestions for further discussion.

- \* re-orient the field workers, FWAs and FPIs, on the importance of male involvement in the FP. program through re-training and supportive supervision.

- \* ensure that the FPIs committedly follow their assigned responsibilities, recently redefined, in respect to contacting specified number of males to provide proper information on FP.and motivate them to accept male methods or become supportive partners to their wives to practice contraceptives of their choice.
- \* reactivate the motivational efforts towards males by re-designing program approach
- \* design appropriate IEC materials for male motivation. These materials should properly highlight the role and responsibilities of responsible parenthood and reasons for regulating their family size.
- \* help develop operational policy guidelines in order to reformulate the program strategies
- \* undertake more experimental/operations research projects in order to evolve appropriate program strategies directed towards effective involvement of males in the FP. program.

I thank you all very much and hope that with your professional wisdom and field experiences, you will come up with implementable recommendations for effective involvement of men in family planning.

***MALE MOTIVATION PROGRAMME FOR IMPROVING  
REPRODUCTIVE HEALTH***

**Ahmed Neaz  
Hasina Banu  
Jahangeer Alam**

Paper presented at the Workshop On  
Male Involvement in Family Planning: Experiences From Innovative Projects  
Rajendrapur, Dhaka, August 7, 1997

## 1. Introduction

The Family Planning (FP) Programme in Bangladesh has emerged through a series of development phases in pursuit of a favourable balance between the country's human and natural resources. During the past few decades the challenge of population explosion became increasingly formidable. Wide ranging policy options have been undertaken in different phases in the face of a growing socio-economic and ecological predicaments.

## 2. Background

The FP programme in Bangladesh is directed almost exclusive on women. Little attention is given to the role of men. Few promotional activities focused specifically on men. In a male dominated society where every decision including family matters are almost unilaterally taken by male, effective male motivation cannot be substituted by any other measures to ensure sustainable fertility reduction measures.

The role of FPAs as male motivators does not seem to be performed as expected (Neaz, Banu 1994). Virtually the role of FPAs has been shifted from the role of male motivation to the supervisory role over Family Welfare Assistants (FWAs) whose target has been always female clients and the designation has been changed to Family Planning Inspector(FPI). Due to a lack of motivational work among men following misconceptions regarding male contraception are found in the rural Bangladesh.

- Vasectomy is a form of castration
- Contraception reduces sexual potency
- Contraception affects ability to perform manual labour.
- Ignorance indifference and insufficient knowledge about FP turn out to be inimical for husband wife co-ordination to make decision to use contraception.

AVSC International has a long-standing commitment to develop services and information that encourages & enables men to fully participate in reproductive health. Over the past 50 years AVSC has worked on behalf of male clients in several ways;(a) expansion of no-scalpel vasectomy throughout the world, (b) producing training materials addressing the specific needs of men, (c) providing technical assistance to improve men's reproductive health services in United States, Latin America, Asia and Africa.( AVSC International, 1996).

The programme of Action, adopted by consensus at the 1994 International conference on population and Development (ICPD), emphasizes the need for equity in gender relations and responsible sexual behaviour. A United Nations Report stated --"*the objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles*"--- (UN Report, 1992).

In many countries of the world outdated policies and regulations are hindrances to male-involvement . The service delivery systems are almost entirely oriented to women and often provide little or no information about male contraceptive methods or male sexual &

reproductive issues (Physicians often report negative attitude towards vasectomy (UNFPA,1995).

### 3. Objectives:

The Objective of the Male Motivation programme for improving reproductive health in Bangladesh are:

- ♦ to reduce misconception among males
- ♦ to improve husband- wife coordination
- ♦ to motivate males to understand country's population problem
- ♦ to enhance knowledge, attitude and practice of contraception & reproductive health among males.

### 4. Strategy :

The strategy of Male Motivation Programme has been directed to link existing Programmes and interventions with the objectives rather than duplicating or overlapping these efforts. Policy interventions have been formulated in such a way that it could strengthen the capacity within government system to identify, develop, implement, coordinate and evaluate such programme.

### 5. Field Interventions:

The field interventions of the Motivation Programme cover social awareness about the danger of population explosion, better future through Reproductive Health(RH) programme and about small family norm. Misconception will be removed by providing proper knowledge about different contraceptive methods. Social awareness will create congenial atmosphere and attitudinal changes among the non acceptors and particularly those who oppose contraception. Following interventions are currently being given:

**Worker Male Client Contract With The Message Of Reproductive Health :**Primary intervention of the project is to establish field worker male client contact on a regular basis. FPIs are persuaded to perform their activities on a regular basis according to their existing job description particularly in the area of male contact. Domiciliary level contact may not be possible in the case of male since only one FPI is posted in a Union level. Instead of domiciliary services for male, cluster contact is more feasible. The worker client contact has been established with substantial message of Reproductive Health(RH). Particular emphasis has been given to males so that they accept a method themselves when their wives suffer from side effect. Relative advantages of male methods will be disseminated to the clients.

**Cluster meeting :** Proper clustering has been made involving 8-12 males from the same locality. They are visited regularly in a school or a club or a suitable place acceptable by the clients on a regular interval. Cluster meeting has been made more interesting by film shows and folk songs. Some entertainment programmes are occasionally organized involving several clusters.

**Involvement of Community Leaders and Religious People :** Local community leaders and religious people have been persuaded to promote RH programme and unitedly face any opposition. Participation of people with different walks of life may take shape of a social movement in the locality. Massive IEC campaign has been launched in the locality to create

extra demand for fertility reduction as well as supply side has been strengthened to meet this demand.

**Networking with other NGOs :** Proper networking has been established with BRDB, Proshika and other NGOs. The credit programme groups of NGOs are working in collaboration with MM Project.

**Community Level Workshop :** A workshop has been organized in Senbag thana to train the GOB and NGO staff and community leaders involving experts from Population Council, CIDA and DG-NIPORT.

**Selection of Motivators :** In every village of rural Bangladesh there are some conscious and dedicated personalities who are willing to work voluntarily for greater interest of the nation. Those people have been identified and their services are utilized in achieving project objectives. They are termed as motivators and for each cluster at least one motivator is selected.

## 6. Methodology :

### 6.1 Implementing Agency :

The Centre for Integrated Development Studies (CIDS) has initiated the Male Motivation Programme within the MOHFW and is pursued by Directorate of Family Welfare at thana level with the help of FPIs. CIDS has established an office at thana level and is providing training and counterpart support to FPIs.

### 6.2 Intervention area :

Senbag thana of Noakhali district has been selected for Male Motivation Programme. Selection of thana has been made considering the low performing area of the country where no NGO is working. The intervention area comprises six unions of Senbag thana. Three unions of this intervention area have been considered for both intervention and counterpart support (Treatment 1), in the other 3 unions, training has been provided to FPIs but no counterpart support is given (Treatment 2). Adjacent to Senbag, three unions of Companigonj thana have been taken as the comparison area where no intervention, training or counterpart support is given.

### 6.3 Household Survey :

Two surveys were originally planned one for the baseline information of the treatment and comparison areas which would be used as the bench mark. In the end of the programme an evaluation survey will be conducted to measure the effectiveness of the intervention and changes occurred in the community.

**Baseline Survey :** The baseline survey has been conducted prior to the implementation of the Male Motivation Programme in treatment 1, 2 and comparison areas taking 400 samples (200 male + 200 female = 400) from each of the areas (400 x 3=1200).

**Evaluation Study :** In the end an evaluation study will be carried out to see the overall results, impact of different interventions, its effectiveness and possibility of further replication in the national programme.

## 7. Major Findings of Baseline Survey :

**Contraceptive use status :** The intervention and comparison areas, belonging to the low performing region of the country, have lower contraceptive use rates than the national prevalence rate (48%). At the time of baseline survey the contraceptive use rates were 35.5 percent in Treatment 1, 40 percent in Treatment 2 and 38.3 percent in Comparison area. The use of contraception was overwhelmingly dominated by female methods. As regards the use of specific methods, pill was the most commonly used method followed by tubectomy and injectables (Figure 1, Table 1).

**Male Contraception :** Male contraception was extremely low (2.9) in the study areas. The use of condom was 2.6 percent and vasectomy (male sterilization) 0.3 percent.

*Men do not have any knowledge of traditional male methods such as periodic abstinence and withdrawal. Even some of the FPI do not know the use of these methods.*

Table 1. Methodwise Contraceptive Use rates in Treatment 1, 2 & Comparison areas

	Treatment 1	Treatment 2	Comparison	TOTAL
	%	%	%	%
Pill	21.0	19.0	20.3	20.1
<b>Condom</b>	2.8	3.0	2.0	2.6
Tubectomy	3.5	8.0	5.5	5.7
<b>Vasectomy</b>	0.5	0.3	0.0	0.3
Injectable	6.3	7.0	4.0	5.8
IUD	0.3	0.5	5.0	1.9
Foam/jelly	0.0	0.3	0.0	0.1
Rhythm	1.3	2.0	1.5	1.6
Withdrawal	0.0	0.3	0.0	0.1
TOTAL user	35.5	40.3	38.3	38.0
Never user	44.0	41.8	45.5	43.8
Ever user	20.5	18.0	16.3	18.3
Sample Size	400	400	400	1200

**Sources of method:** The current users were asked about the sources from where they get the supply of methods. About 43 percent of them in Treatment 1 area have reported that they usually get it from shops and 36 percent reported that they get from FWAs (Table 2).

**Side effect problem :** The current and the past users were asked whether they had any side effect problem while using a method. In all the areas 27 percent of users reported to have some kind of side effect problem.

Table 2. Sources of contraceptive methods as reported by the respondents

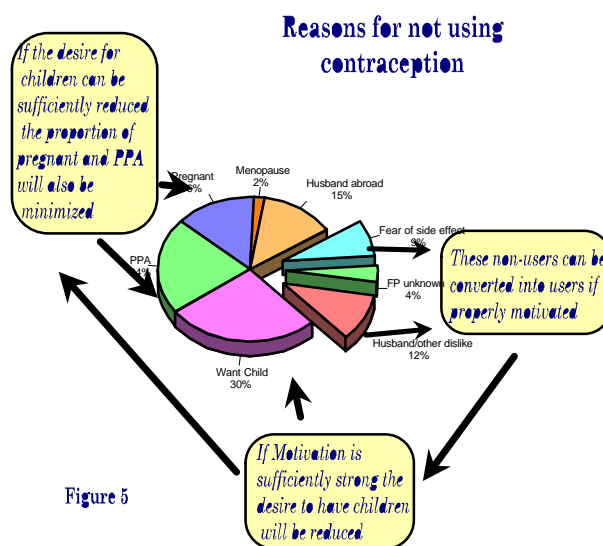
Sources	T 1 %	T 2 %	Comp %	Total %
FWA	36.0	23.5	28.1	29.4
Dai	0.0	0.5	0.0	0.2
Shops	43.0	27.9	21.4	31.0
Husband	16.5	14.2	21.4	17.4
Neighbour	0.5	0.0	1.0	0.5
Other/FWC/ Satellite	4.0	33.9	28.1	21.6
Sample Size	200	183	192	575

**The Reasons for not using contraception :** At the time of survey the respondents who were not using contraception were inquired about the reasons for not using. The most commonly reported reason in all the areas was ‘want children’, followed by ‘breast feeding and PPA’, ‘pregnant’ and ‘husband abroad’ (Table 3). Other reported reasons were ‘Husband or others dislike’, ‘FP use not known’ and ‘fear of side effect’. The fear of side effect can be mitigated by switching from female method to a male method such as condom which has no side effects (Figure 1). The ‘methods not known’ and ‘husband’s disliking’ can be sufficiently reduced by the Male Motivation Programme.

*Men demand more choices of methods. They do not have much choices as women have. Vasectomy is not considered to be a suitable method and condom is the only method left for choice.*

Table 3. Reasons for not using contraception by area.

	T 1 %	T 2 %	Comp %	Total %
Want children	35.4	29.3	25.9	30.3
Husband.	7.8	9.3	6.1	7.6
Dislike				
Others Dislike	4.7	4.2	7.3	5.4
FP unknown	4.3	3.3	5.3	4.3
Fear of Side Effect	12.8	5.6	7.7	8.9
Pregnant	17.1	15.3	16.2	16.3
PPA	19.8	31.6	21.5	23.9
Menopause	3.1	1.4	1.2	1.9
Childless	0.0	0.5	0.0	0.1
Husband abroad & other	12.1	14.9	18.6	15.2
Sample Size	257	215	247	719



**Ideas, Perception and Attitude towards Contraception :** During the survey it was inquired whether women have asked their husband to use a method. Majority of them did not asked their husband to use, only 28 percent have asked. Since women have to bear all the physical discomforts during pregnancy and the trouble of child bearing and rearing, they have an idea that contraception is their own responsibility. They don't want to impose the responsibility to their husbands who are the only earning member in the family. The proportion of women, who did want to share the responsibility, had asked their husbands to use a method. Two third of those husbands, who have been asked, did not agree to use (Figure 2).

Men also were asked whether they were willing to use a method if their wives have side effect. Surprisingly 70 percent of them were not willing to use (Figure 3). Thus, it shows that men also think that contraception is the wife's responsibility and if she has side effect she will solve her own problem, it not their matter of concern.

The respondents who were against family planning greater number was found among males. Most of them have indifferent attitude towards family planning. This shows that men are less motivated than women.

*During the course of the interview men were reluctant to answer the questions and did not pay much attention to the questions being asked. Sometimes provided indefinite answers.*

Misconceptions substantially prevailed in all the areas, about 25-32 percent respondents believed that vasectomy is a form of castration, 35-54 percent believed that contraception reduces sexual potency and 41-53 percent believed contraception reduces ability to perform manual labour.

**Desire for Children :** Husband and Wife's actual desire for children and their satisfaction with gender combination was ascertained. It was interesting to note that couples who already had 2 children (1 son and 1 daughter) nearly 50 percent of them desired additional children, either 1 son or 1 son and 1 daughter. Wife's desire was less if they had 2 sons but if they have 2 daughters 100 percent of them desired additional children (1 or 2 sons).

*Women reported that they are cursed in the society if they give birth to only daughters. Mother of a son has higher social status than the mother of a daughter. During old age women live with their sons. Thus, sons provide old age security.*

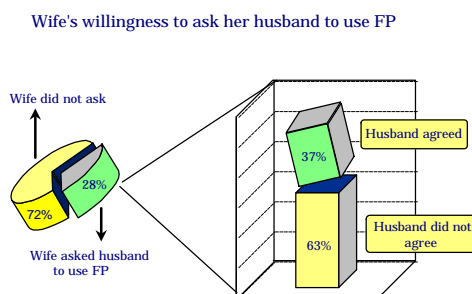
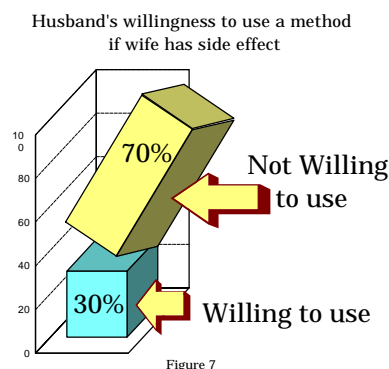


Figure 6



**Ideal Family Size :** About 50 percent of males and 66 percent of females have reported that 2 children ( 1 son and 1 daughter) is the ideal family size. Three children as the ideal family (2 sons and 1 daughter) is also preferred by 17-27 percent of respondents, the percentages are higher among males. Four children as the ideal family (2 sons and 2 daughters) is quite unexpectedly high (15-18%). It is evident that male's perception of ideal family size is greater than the females. These issues have been taken by the Male Motivation Programme. The IEC campaign of two child norm does not seem to be very effective in these low performing areas.

## 8. Conclusion :

During the interview it was observed that men are reluctant to answer the questions, they do not pay much attention to the questions being asked. On the contrary, women's answers were more prompt and specific. It may be due to the fact that women are frequently interviewed by different researchers and are visited by either GOB or NGO workers. They are used to this kind of questions and are much more prompt. Men are rarely visited by interviewers or field workers, thus they have greater inconsistency between their answers compared to women. For example, when they were asked about the awareness of the country's population problem and their responsibility to solve the problem, almost all of them replied that they are aware of the problem and have responsibility to solve it but their desire for children was higher and attitude was not in favour of contraception. Men's awareness of country's problem is perhaps not exactly the awareness rather just they have heard about it, their knowledge is superficial and do not realize the consequences. It is expected that the Male Motivation Programme in these areas will bring some changes in the ideas and perception of the community.

*Male Participation : The Key to Future Family  
Planning Programme Success*

**MD. NAJMUL HUQ**

Paper Presented at the workshop on Male Involvement in Family Planning: Experiences From Innovative Projects, Rajendrapur, Dhaka, August 7, 1997.

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Center for Population and Development (CPD)  
Dhanmondi, Dhaka, Bangladesh

## **1. Description of the Project**

The project has 3 distinct phases:

**Phases I:** To conduct an in-depth **Baseline Survey** in order to measure the overall situations and status of males' feelings, attitude and participation in family planning programme in Sonargaon Thana and thereby to identify some IEC and programmatic interventions to be adopted for greater male participation in family planning.

**Phase II:** Based on the survey findings, a few selected intervention models would be put into **operation and tested** in 3 selected unions of Sonargaon Thana for a period of six months.

**Phase III: Final evaluation and consolidation** of the intervention results.

## **2. The overall objective of the project was**

**To encourage and to attain** maximum male participation in all aspects of family p programme through field investigation followed by programme interventions.

An indepth baseline survey was conducted with 480 respondents, male non-users, service-providers, community leaders and thana level officials. The findings are as follows:

## **4. FINDINGS**

### **a) Male Non-users**

- ☆ The mean age of the non-users are above 35 years and a large number of them (44%) are illiterate, while more than one-fourth of them had primary level of education. The largest number of male family planning non-users (38%) are found to be engaged in small business .They have an average monthly income of little of over Tk. 2600/-.
- ☆ More then One-third of them did not visit any government or private health facilities for treatment.
- ☆ Among the female methods, the male non-users have knowledge on oral pill and injectable. Among the male methods, condom is well known to them and considered as the best one. However, knowledge on permanent methods of vasectomy and tubligation, is found to be poor.
- ☆ A vast majority of the non-users (88%) were first exposed to family planning information only after their marriage
- ☆ Regarding use of family planning method by males , majority of them opined that it depends on the decision of both husband and wife . Again a good number of them (44%) opined that family planning method use by males depends only on the self decision.

- ☆ More than 80% of the male non-users expressed their positive intention to use family planning in future.
- ☆ Overall exposure to family planning IEC media, materials and messages by the male non-users are very poor. 90% of the non-users are exposed to Radio, while only 51% to TV programmes on family planning.
- ☆ The majority of them suggested to arrange recreational programmes like folk song, drama, film show and group meetings for dissemination of information and motivation of the males.

#### **b) The Service Providers**

- ☆ The FPIs are found to be the oldest in respect of age and length of service in family planning programme while the NGO workers are the youngest both in age and in length of service.
- ☆ Almost all of the service providers are married. The FPIs are having 19 years of average married life, followed by FWAs and FWVs with 14 years.
- ☆ The FPIs are also having on average, 3 living children, followed by FWAs who are having more than 2 children.
- ☆ It is interesting to note that more than half of FPIs and one-third of FWAs and three-fifth of NGO workers do not use any family planning method.
- ☆ As to the use of the male methods, none of the service providers or their partners have undergone vasectomy and only one SACMO and one FWA reported to have accepted tubectomy.
- ☆ More than 60% of the service providers do not intend to accept vasectomy for themselves or their partners.
- ☆ One-third of FWAs and little less than three-fourth of FWVs have no IEC materials with them.
- ☆ The majority of the service providers (55%) however, viewed that the limited choice of male methods is the major reason for low use of male methods.
- ☆ All service providers, except the FWVs, have expressed the opinion that all of them (100%) have the responsibility for male motivation as part of their job. Majority of the FWVs (57%) have also expressed the same opinion.
- ☆ The interpersonal communication (face-to-face contact) is found to be the most popular medium of client communication among the service providers.

- ☆ 99% of service providers opined that condom is the most popular method among the males in the area.
- ☆ More than two-thirds of the service providers suggested to introduce porters, leaflets, and sign boards on male methods in the locality in order to create male awareness and thereby encourage males to participate in family planning. A good number of service providers also suggested **to arrange folk song/drama/movies, motivate males by elders and social elites, arrange male motivational meetings and also to explain religious views on family planning by Imams** as local program interventions which may be adopted to encourage males to participate in family planning and accept its methods.

### **C : Community Leaders**

- ☆ The mean age of the community leaders is around 43 years and almost half of them have education beyond higher secondary level.
- ☆ All of them are married and having on an average, 4 children, with youngest child with mean age of more than 6 years.
- ☆ The community leaders have good knowledge on most of the modern methods. Among the male methods, more than four-fifths of the community leaders have knowledge on condom and less than three-fifths have knowledge on vasectomy.
- ☆ Almost all the community leaders are the supporters of family planning programme.
- ☆ More than half of the community leaders are not current users of family planning methods. Even then, a large majority (85%) of them have discussed family planning with their wives and most of them (93%) also discussed family planning with their relatives and friends.
- ☆ A vast majority of the community leaders (78%) opined that the service providers do communicate with them and sought different types of assistance for implementation of family planning program. The major assistance the service providers sought for is related to motivation of public.
- ☆ Majority of the community leaders viewed unwillingness of males to use a male method as the main reason for low use.
- ☆ The community leaders give priority in educating the males on family planning methods and also emphasized to address social and religious prejudices through media.
- ☆ The Union Parishad Chairmen and members have expressed their explicit role and willingness to participate in different male motivational activities.
- ☆ The Imams have indicated that they can play a significant role in favour of family planning in religious gatherings .

- ☆ The elites/youth leaders emphasized the needs for arranging motivational meetings and seminars for the males including creating awareness among the males on the benefits of small family.
- ☆ The school teachers identified their role in motivating the guardians in school meetings and also to participate in community meetings to educate and motivate the rural males.
- ☆ A large majority of the community leaders have exposure to both Radio and TV programmes on family planning.
- ☆ A good number of community leaders (37%) suggested to arrange family planning related recreational programs such as folk song, drama, film show, mela and sports.

#### **D : Thana Level Officials**

- ☆ The mean age of these officials is 37 years with more than 11 years of services.
- ☆ 60% of them are working in this Thana for less than 2 years.
- ☆ Except 1, all are married with mean duration of married life of more than 10 years. 29% of them have no child while 57% are having 1-2 children and the mean number of children is 1.7.
- ☆ The mean age of their youngest child is 7.7 years.
- ☆ Two-thirds of them are the currently contraceptive users, of which 33% and 20% are using condom and traditional methods respectively.
- ☆ None of the officials or their partners are using oral pill, while this method is the most popular in the national contraceptive use. None has had vasectomy.

### **5. Focus Group Discussion (FGD) Results**

#### **Sampling and Formation of Groups**

The focus group was a special type of group in terms of purpose, size, composition and procedures. The focus group participants were broadly categorized into two district groups :

I) **Service Providers** (FWAs, FPIs, MAs, FWVs and NGO workers).

ii) **Community and opinion leaders** (Union Parishad Chairman and members, school teachers, Community and religious leaders).

The following major sections, each section having 3-4 relevant, thought-provoking and opinion-seeking questions have responses by the participants.

**I) Responsible parenthood.**

**ii) Interspousal communication and family decision-making process.**

**iii) Family life in the context of socio-cultural and religious issues.**

**iv) Family planning communication, motivation and perception of IEC materials.**

**v) Use of FP methods.**

**vi) Male participation and use of male FP methods.**

**6. Recommended Interventions**

**A. IEC interventions**

I. Local folk media such as folk songs, drama, jatra, mela etc. are to be organised.

II. Motivational contacts and campaigns are to be undertaken by male volunteers, local leaders, and male field workers.

III. The role of males/husbands in family planning is needed to be publicized.

IV. 'Husband Day' at FWCs is to be observed once a month.

V. Appropriate slogans and messages on male participation in family planning are to be developed and disseminated.

VI. Group meetings, and lecture sessions with specialized male groups and targeted audiences are to be conducted.

**B. Programmatic interventions**

I. Male motivational efforts are to be strengthened.

II. Male volunteers are to be deployed .

III. The role of FPIs are to be geared up.

IV. Special vasectomy camps are to be organized.

V. Special service delivery systems for males at the mills and factories are to be introduced.

**A. Interventions :**

On the findings of the Baseline Survey and on the recommendations of the dissemination seminar, the following programatic and IEC interventions are now being implemented in 3 unions of the project :

## Programmatic Interventions

<u>Sl. No.</u>	<u>Interventions</u>	<u>Results</u>
1.	<b>Deployment of Male Volunteers</b>	30 male volunteers were selected and trained in order to work with the FWAs, particularly for male contact and motivation. These local volunteers have facilitated male motivation and participation in F.P. programme.
2.	<b>The role of FPIs are to be geared up.</b>	The FPIs are the direct supervisor of the local volunteers and as such they provide all the guidance and assistance to the volunteers. The FPIs became more involved in male motivational programmes.
3.	<b>Special Service delivery for males at FWCs, Satellite Clinics and in special camps.</b>	Efforts are made to improve the quality of services at FWCs, Satellite clinics and at special camps for male method acceptors, The acceptance rate of vasectomy and condom has significantly improved.

## IEC Interventions :

<u>Sl. No.</u>	<u>Interventions</u>	<u>Results</u>
1.	<b>Use of local folk media for male motivational Campaigns</b>	Local Folk Singing Team is deployed to sing at important hats and at FWCs compound focusing male participation and male methods. Such programmes attracted a large gathering of males.
2.	<b>Male Motivational contacts by the Volunteers, local leaders and field workers.</b>	A list of non-user couples was prepared by the volunteers, and direct face-to-face contacts are being made for FP acceptance, specially by males.
3.	<b>Husband Day at FWCs are organised .</b>	A fixed date on every month is earmarked as Husband Day in each FWCs where the couples are invited to visit the FWC in order to see the functioning of the FWC, its equipments, medicines and contraceptives and other facilities. On this occasion, some

special programs such as miking, folk songs, sports for children, baby show etc are also organised. Such programmes attracted a large number of couples particularly the males.

4. **The role of husbands in FP programme are publicized**

The role of husbands in different issues of FP is highly publicized. For this purpose, posters with slogans/messages have been locally developed and thoroughly disseminated in the project area.

5. **Group meetings with special male groups are organised**

Special Group meetings are held regularly with the school teachers, Youth clubs, industrial workers, and informal community leaders. Sometimes such meetings are also held at Satellite Clinics. Such programmes have created awareness among the males and sensitized them in FP matters.

## **B. The Field Problems**

Till date, the following problems are faced :

- I) Lack of male interest in FP programmes
- ii) Difficulties in contacting the males at homes.
- iii) Fear of vasectomy.
- iv) Limited choice of male method
- v) Non-existence of static male service delivery points (MSDP)
- vi) Lack of male targeted IEC materials

## ***MALE INTERVENTION PROJECT***

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## Background

The national family planning program of Bangladesh has made an impressive progress in achieving 49 percent CPR and also bringing down the TFR to 3.3 per women (BDHS,1996-97). If the present rate of contraceptive prevalence has to be sustained with quality and the national goal of reaching the replacement level of fertility has to be achieved by 2005, innovative program interventions need to be identified and implemented.

In the national program, several attempts have been made in the past to identify critical issues which need to be addressed on a priority basis in order to further improve the program performance. The National Steering Committee, in its Plan of Action for Future Challenges in the FP/MCH program, identified eight immediate priority areas. Critical under-served group is the priority, while men and the newly married are the two important under-served groups identified.

There are good reasons to work more directly with men. In Bangladeshi society, men are considered as the dominant members in any family decision-making, including the use of FP methods. Therefore, greater involvement of males in FP is now a prime need. Male involvement in family planning refers to mainly two distinct yet inter-related programmatic goals. Firstly, it encourages use of male methods and includes supporting role in the use of female methods as well. Secondly, it implies the expanding involvement of men in FP decision-making with respect to method use.

There is now a growing consensus among program managers to make a stronger effort to involve men in the family planning program. But the existing FP structure does not reflect this perspective, given its strong female orientation. Both the deployment of a large number of female field workers at the community level and the use of female paramedics at Family Welfare Centers(FWC) and Satellite clinics(SC), designed to cater to the needs for women and children only, have made it easier for women than men to get information and services. Thus, the needs for participation and services of men have been largely overlooked.

It is evident from different studies that almost 15.0 percent of female clients discontinued their method-use because of husbands' objections or their unfavorable attitude (CPS,1991) and 5.0 to 14.0 percent of eligible female clients, who intended to use FP. methods, stated husbands'objections/ disapproval as one of the reasons for non-use of contraceptives (BDHS,1994). Moreover, male sterilization accounts for a little over 1.0 percent as terminal methods and condom use is also very low, 3.9 percent (BDHS,1996). Out of a total prevalence rate of 49.0 percent, the current use of methods by males is only 7.0 percent. This indicates a large non-use of methods by the males and it may be a contributory factor underlying the country's widespread problem of unmet needs.

The female field workers do not prioritize contacting the male partners of the couples during their home visits.The majority of them feel still shy to talk to males about family planning and also feel uncomfortable discussing and explaining how to use male methods of contraception. Moreover,the FPIs are supposed to contact and organize group meetings with males for motivation; but this is not happening. Another factor is the program effort that emphasizes household distribution of resupply methods for women,mainly oral pill. So programmatic efforts should derive appropriate strategies to initiate and sustain male involvement in family planning method acceptance.

In a seminar sponsored by the Population Council on Male Involvement in Family Planning, the participants strongly advocated the need for concerted efforts to involve men more actively in family planning program. These efforts should help facilitate interspousal communication resulting in responsibility-sharing for an ideal family size and contraceptive acceptance.

Views of the husbands and wives on contraception often do not coincide. A better understanding of reproductive roles by men and joint decisions by couples could improve the effectiveness of FP. program performance. There is also a need to launch an intensive IEC campaign to sensitize and inform various groups of male population about the importance of involvement of males in the FP. program. Experiences indicate that increased rates of contraception and continuation of female methods are higher when husbands are involved or couple-focused approach is adopted for decision-making.

This scenario calls for designing appropriate interventions and action plans for effective involvement of males and sustaining their participation in FP. method acceptance, especially for male methods. The present operations research project was developed and is being implemented to field test the assumptions stated above.

## **OBJECTIVES**

The broad objectives of the project are to identify the socio-economic and programmatic factors influencing increased level of acceptance of FP methods and to design and test appropriate strategies to accelerate proactive male involvement in the program.

The specific objectives of the Male Intervention Project for promotion of family planning services are to:

- reduce misconceptions about the use of family planning methods, especially condom and vasectomy, among men through development and distribution of appropriate IEC materials;

- create an attitude towards a sense of responsibility among men to support their wives to use contraceptives and help continue the methods;

- enhance field workers' interaction with males in order to increase knowledge on FP. methods for males and thus raise the acceptance rate of male contraceptives, specially vasectomy;

- assess the level of increase of male users attributable to the introduction of male friendly clinic hours and programs; and,

- increase the NSV acceptance among males particularly among couples wherein the wives are long term users of spacing/resupply methods.

## **Program Implementation Plan**

Conduct situation analysis to assess: i. the present status on attitude of service providers in providing services to the males; ii. service facilities; iii. equipment, training needs etc.;

Orient the front line Govt. and non-govt. field workers and service providers about the importance of male participation in the program;

Design, develop and use appropriate IEC materials concerning all aspects of the program encouraging male participation and forming cooperative attitude between males and females and also between providers and the males;

Organize special hours in a fixed day for men to provide information and services on FP/MCH and other health related issues from selected FWCs;

## **PARTNERSHIPS**

This is a joint project of the Directorate of FP, NIPORT and the Population Council.

### **The Directorate is responsible for:**

- \* selecting a thana for interventions
- \* ensuring that all officials are in position
- \* revising working hours for men at service points
- \* arranging orientation meetings with all concerned officials

### **NIPORT is responsible for:**

- \* serving as a primary focal point for interventions
- \* conducting the situation analysis study for the selected thana
- \* assessing needs for training, particularly on NSV

### **The Population Council is responsible for:**

- \* contracting the IEC consultant to design and pretest IEC materials
- \* arranging the master-trainer consultant for NSV training
- \* assisting NIPORT in conducting the situation analysis and conducting the training needs.
- \* conducting final evaluation of the project about its outcome

## **STATUS OF IMPLEMENTATION OF THE PROJECT**

### **Technical Advisory Committee(TAC)**

A TAC has been formed with Director General,NIPORT and Director General,FP. as chairperson and co-chairperson respectively. In addition, Director(IEM), Director(Research), a representative from the Planning Cell of the Ministry of Health and Family Welfare,three representatives from Population Council,and a representative from an NGO as members.The Coordinator of the MIP is the member-secretary.

The committee is responsible for providing guidance, ensuring proper implementation of the interventions and monitoring its performance.

### **Selection of Thana**

Kalihati thana of Tangail district has been selected as the project area. Kalihati is a medium performing thana as per MIS report. It is well connected by road and that will help the implementors with an opportunity to make frequent visits to monitor the implementation of the project activities.

The total staff strength of the thana are:four officers, 11 Family Planning Inspectors(out of 12), 69 Family Welfare Assistants,13 Family Welfare Visitors,9 Medical Assistants. There are 9 FWCs,8 health sub-centres. In addition, regular satellite clinics are organized in the project area.

### **Orientation Meetings with District and Thana level Officers**

An orientation meeting with Deputy Director of Tangail, Thana Family Planning Officer, Asstt.Thana Family Planning Officer, Medical Officer(MCH/FP), Sr.Family Welfare Visitor of Kalihati thana was held. In this meeting, the district and thana level officers were briefed about the importance and objectives of the project. The officers realized the importance and were enthusiastic about the project and showed keen interest to implement it.

### **Focus Group Discussion with the FPIs**

An FGD with 11 Family Planning Inspectors(FPIs) of Kalihati thana was conducted by NIPORT with the technical assistance from Population Council. FGD was organized to assess, in depth, the problems relating to less participation of males in family planning and thus low acceptance of male methods, specially condom and vasectomy. It was also intended to identify the probable interventions for increasing participation of men and the acceptance of male methods,specifically vasectomy.

### **Situation Analysis**

A situation analysis study was conducted with 69 Family Welfare Assistants(FWAs) by NIPORT.The purpose was to assess the present status of education-motivation efforts undertaken for the male clients by the FPIs and FWAs and the problems encountered with the male involvement in family planning program.

The findings are expected to evolve factors which might help seek support from male partners, problems relating to low use of male contraceptives and to suggest suitable interventions for greater involvement of men in FP. program with special emphasis on promotion of male method-use.

Information about the level of male involvement and reasons for their indifference or less participation in FP. were not collected at the clients' level. But literature on male participation were reviewed. This review of literature has provided several social, psychological and programmatic reasons for lower acceptance of male methods.

The main findings from FGD, situation analysis and also information obtained through field visits are as follows. These have helped identify relevant interventions for the project.

Great majority of the FWAs discussed FP methods with female clients only.

Husbands were left unattended and even overlooked in either information provision or motivational efforts about family planning methods.

Two priority FP. methods, tubectomy and oral pill, were emphasized during discussion with female clients, as the motivational efforts were mainly directed towards females mainly.

Contacts with males and their motivation in general, and use of male methods in particular, have not been given due importance at all, rather were largely overlooked, by the field workers.

Husbands showed less interest and took less initiatives than their wives either to use contraceptives by themselves or to encourage their wives to use methods.

Husbands, in most of the cases, do not extend any help to wives specially in case of management of side-effects; even they resist continuation of methods use.

Many female clients, who have been using temporary modern methods, are facing problems of misunderstanding/ conflicts with husbands, because the use of methods was not a mutually supportive decision.

The field workers expressed consensus opinion that both husbands and wives should be contacted and motivated, preferably in joint sessions.

The inevitable gap in the program is that the field workers concentrate their efforts to contact mostly the female partners of the couples to provide information and services on FP-MCH, while strongly feeling the necessity to motivate husbands and wives jointly to promote use of contraceptives.

The FWAs have not been given a realization, during training or re-training and even during supervisory visits, of the importance of male's participation in FP.

The field workers advocated joint decisions by both husbands and wives to have increased use of contraceptives and also their continuation.

To enhance contraceptive use, increasing involvement of men in the FP. program and particularly use of male methods are of a dire necessity, the FWAs opined.

Since rumors and misinformation about male methods still exist, there is a need to develop IEC materials exclusively for men for their information on FP., especially on complete knowledge of different family planning methods and also how to use them.

The information-motivation efforts in the past were targeted to females mainly and it failed to give importance to the opinion of males in contraceptive decision-making.

The female partners of the couples are reported to be the barriers to the use of male methods of contraception, specially they still have misconception about vasectomy. Wives apprehend that after having the vasectomy done, husbands will be physically weak and be unable to work hard resulting in more economic hardships to the family. So it is necessary to re-educate the wives who, in turn, can play an active role in motivating their husbands to use male methods which are easy and safe to use.

Since no concerted effort was made in the past to make different segments of the community influential aware of the importance of male involvement in the FP. program, group meetings with married males need to be organized to sensitize them in order to seek their support.

The literature review has provided some important issues which negated the males to actively participate in the FP./MCH program. Here only the programmatic issues are presented.

### **Programmatic:**

There are very limited choices of male methods, only withdrawal, condom, vasectomy and periodic abstinence also. The present service provisions do not also adequately welcome men to receive required services.

IEC materials exclusively for male motivation are very limited and even not available.

At the field level, the FPIs are the only male workers who did not perform their assigned responsibilities in contacting and providing men in group with proper information on male methods and encourage them to accept methods of their choice.

The major emphasis through training and job orientation of the FWAs, was directed to contacting the female partners of the couples and informing/ educating them about the contraceptives. The field workers have not even been advised on the importance of male's involvement or encouraged to contact males for motivation during the usual field visits by the supervisory officers.

FP/MCH services are mainly aimed at women and children.

There are rumors/misinformation about male methods.

These findings, though not comprehensive, indicate that no concerted efforts, programmatic or otherwise, were planned and organized to educate men on the importance of their involvement in family planning. The existing educational approach and programmatic efforts need to be reviewed and modified. Both partners of the couples should be reached. To ensure male participation in fp. program more effectively, it would be necessary to provide men with required and proper information on FP. and its methods through designing appropriate IEC materials. It is also required to make family planning services, targeted to men, easily accessible and available.

On the basis of the above findings, three interventions were identified and are being being implemented at Kalihati. These are as follows:

### **Development and Printing of IEC Materials**

Three different IEC materials were developed, pretested and printed.

These are:

A folder on "Responsible Parenthood" has been designed highlighting the role and responsibilities of men for family-life planning. It contains reasoning regarding active participation of men in family planning and also use of male methods of contraception of their choice. This folder has been widely distributed among the influential males of different social groups. It also serves as an aide to the FPIs and FWAs for motivation purpose for men.

A folder for the "Service Providers" has been prepared and printed to provide necessary information and guidance stating the importance of involvement in of men in family planning. and the motivational strategies to be followed.

A folder on NSV has been printed to provide correct and complete knowledge about different contraceptives and information to dispel misgivings/rumors about vasectomy, and to spell out the simplicity of NSV operation. This will be used by the field workers for motivation of men and by the clinical personnel for counselling.

### **Orientation Workshops for FWAs**

Two orientation workshops were organized after every three months. In the first workshop, the FWAs were briefed about the objectives of project, probable interventions to be experimented and the role of the FWAs in implementing the strategies.

In the second workshop, the IEC materials were distributed to them with the instructions about how to use these, whom to be distributed to and prioritization of their educational efforts for males.

In addition, two more workshops will be organized. In each of these, status of progress on implementation of interventions will be assessed and if necessary, modifications will be suggested. The different activities designed for implementation will also be reviewed to assess the strengths and weaknesses so that corrective program measures can be planned and adopted.

## **Special Service**

This includes a provision for exclusive clinic hours for men initially once a week at 4 selected FWCs with opportunities for men to receive family planning information and services, specially NSV, and other common ailments. Attempts have been made to involve couples, both users and non-users, and also newly-weds in such orientation sessions. These orientation programs are being organized by the FPIs in cooperation with their respective FWAs.

These orientation meetings will include discussions on male's role in family life planning, reproductive health, necessity for interspousal communication in decision-making for contraceptive use. Special efforts should be made to address the female partners of the couples to encourage and also persuade their husbands to use male methods.

In addition to these interventions, a supportive supervision model has been developed and now in practice by the four supervisory officers of Kalihati thana.

## **Initial Outcome of the Project**

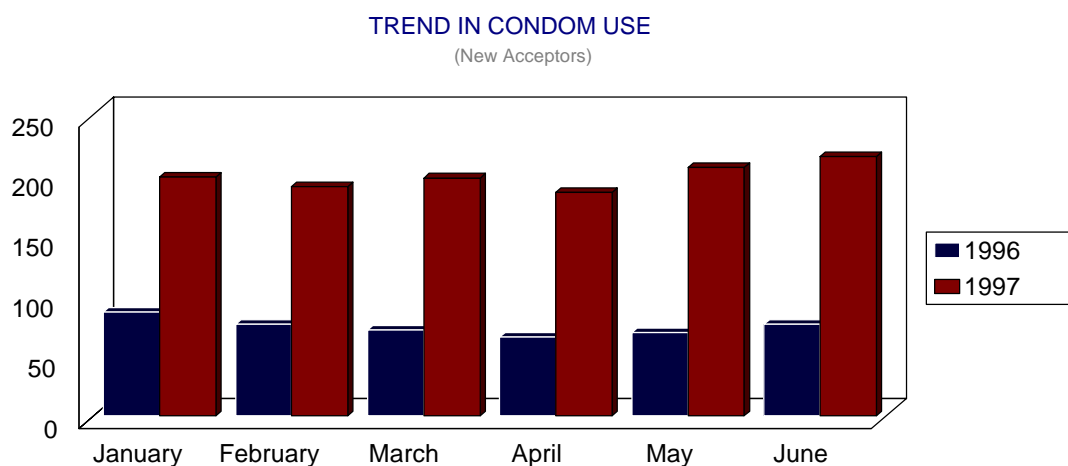
It is too early to expect a tangible results out of this project, but there are positive indications that the findings of the project would contribute to the development of a program directed towards achieving male participation. The short-span program interventions tried and implemented so far are narrated below:

All program personnel, from thana level to the grass-roots level, have been given a renewed understanding about the importance of participation of men in the family planning program. As a result of initial efforts, a strong realization has developed specially among the FPIs and FWAs on the necessity for active participation of men in the FP/MCH program in order to further increase the CPR.

IEC materials have been distributed to the selected male groups who are, in turn, expected to help the field workers in their motivational efforts towards men.

the FPIs and FWAs are now making systematic efforts to reach men for motivation with specially designed IEC materials.

the use of male methods has been steadily rising. During 1995 and 1996, only one case of vasectomy was done and the proportion of condom use was very low. During the initial phase of the project (4 months), 14 NSVs have been performed. The use of condom (new acceptors) has also shown a rising trend as reflected in the following graph



## Conclusion

Men are the new focus for contraception, and interest in male involvement in FP. program is growing. There is an increasing evidence that such program can be effective in increasing partnerships of both husbands and wives in contraceptive use. It is possible to improve male involvement in family planning, if this issue is handled tactfully and the male partners are made to feel that their patronage is important in the decision-making process for contraceptive use. But such decisions should be joint, rather than individual. Thus communication between husbands and wives can play a major role in increasing male participation in fp. Future efforts to promote fertility regulation need to consider ways to counsel couples together and encourage inter-spousal communication in decision-making.

Male involvement projects can accomplish a great deal by simply paying an attention to male partners. Male involvement does not need to detract women's services; but the goal is to develop a new couples' partnerships based on mutual respect and cooperation.

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**MALE INVOLVEMENT IN FAMILY PLANNING:**

**Experiences from AVSC Activities/Projects**

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## **INTRODUCTION**

Male play a key role in all the development activities including Health and Family Planning, especially in the societies where male hold higher social status and decision making power. Male involvement in family planning, as the literature suggests, focuses on men as users of contraceptive methods, supporters for using methods by their partners, providers of family planning services, and advocates of family planning among the neighbors and in the community.

## **STATUS OF MALE INVOLVEMENT IN BANGLADESH FAMILY PLANNING PROGRAM**

Bangladesh Family Planning program, despite of the unfavourable socio-economic condition, has made a remarkable progress and emerged as a successful program in the world. Knowledge of at least one family planning method is almost universal in Bangladesh. The total fertility rate has declined from 6.3 in 1971-75 to 3.3 in 1996-97 (DHS, 1996-97). The contraceptive use rates has gone up by about twelve times from 3.9 percent in 1969 (Haider, Strietfield and Karim, 1995) to 49.2 in 1996-97 (DHS, 1996-97).

In the backdrop of the above mentioned demographic scenario, we are still lagging behind in active involvement of males in family planning and reproductive health. At the early days of the national family planning program, the acceptance of male methods, especially vasectomy was very popular and over one million of the said procedures were performed during 1965-70 (Rob et al, 1996). Vasectomy remained to be a popular method until 1984-85. Since then, there has been continuous decline in acceptance of sterilization. However, there has been a slow increase in the use rate of condom from 0.7 in 1975 (BFS 1975) to 3.9 percent in 1996-97 (DHS 1996-97). An ethnographic study in rural Bangladesh by Schuler R. Sidney et al suggests that women to women approach strategy in Bangladesh Family Planning program, despite its success in increasing contraceptive prevalence, often fails to provide adequate information, services and ways to involve men in family planning.

## **AVSC MALE PROGRAMS**

For more than 50 years AVSC has worked to increase men's constructive involvement in reproductive health. As part of its efforts, AVSC has worked to increase access to quality sterilization services for men worldwide (AVSC International, Annual Report 96/97).

In Bangladesh, AVSC International has been working closely with the Directorate of Family Planning of the Ministry of Health and Family Welfare for improvement of quality of family planning clinical services including male sterilization services.

AVSC's support include training of physicians in male sterilization services, development of counseling training curriculum and training of counselors, needs assessment for improvement of clinical services, introduction of Non Scalpel Vasectomy, supporting for national workshop on male participation in family planning and a study on vasectomy decision making in Bangladesh as a part of global initiative.

## **INTRODUCTION OF NSV IN BANGLADESH**

Now a days worldwide Dr. Li's Non-Scalpel Vasectomy (NSV) technique is the most popular method of male sterilization. In this procedure of vasectomy a puncture (hole) is made in the scrotal skin without cutting it. Through that puncture the vas are brought out, tied and cut. Only three instruments are required for NSV procedure which are namely Ring Forceps, Dissecting Forceps, and a small scissor. This technique has made vasectomy less painful, incurs minimum blood loss and have a very less chance of infection. Thus NSV is much more safer and convenient than the conventional incisional vasectomy.

Since August 1989 NSV services has gradually been started to be provided in Bangladesh. In 1992 AVSC with its financial and technical assistance started organizing VS training courses through seven NIPORT training centers and NSV technique has been part of the courses. Through its training centers NIPORT has trained more than 200 GOB physicians in NSV technique.

### **VASECTOMY DECISION MAKING STUDY:**

As a part of a strategy to increase awareness and use of vasectomy, AVSC International selected Bangladesh to participate in a global study on vasectomy decision making. The study was completed in middle of 1995. The purpose of this exploratory study was to identify key variables in decision making for vasectomy that will assist in designing appropriate information, education and service delivery approaches to promote the wider use of the method. The study revealed that service providers rarely talk about vasectomy. They should all be encouraged to provide information on vasectomy to all men with whom they come in contact. This would require intensive orientation and skills training in counseling on vasectomy and male participation in reproductive health issues.

### **SYSTEMS APPROACH PROJECT:**

During the last two years AVSC International has undertaken a collaborative program with the Directorate of Family Planning titled Systems Approach Project on client -centered clinic-based family planning services. This paper is focused on this AVSC program, the lessons learned in three conservative and low performing thanas in Sylhet district, and its experience in involving male in family planning programs.

AVSC begun this project in three low performing thanas of Sylhet District namely Golapganj, Jaintapur and Zakiganj. Contraceptives Prevalence Rate (CPR) in Sylhet Division is the lowest compared to other 5 Divisions. CPR is 20.1 percent in Sylhet where as it is as high as 61.9 percent in Khulna Division. Use rate of condom is 1.4 percent in Sylhet Division compared to 3.9 percent of national use rate. The vasectomy use rate is zero in the Sylhet Division(DHS 1996-97).

Prior to implementation of this project baseline information were collected from each of the thanas by an independent local consultant. At the beginning of the project, Client -Oriented Provider- Efficient (COPE) quality management tool was introduced in each of the thana by late 1995. The COPE exercises were participated by the district and thana level managers, thana, Union and community level service providers of health and family planning departments, and representatives of local NGOs.

COPE is a self assessment exercise. The four component of COPE exercise is ( a) self assessment by the staff, (b) interviewing clients to get their opinion as to how the health and family planning services can be improved, (c), Client Flow Analysis to assess the waiting time of the clients and to find ways for maximum utilization of the staff time and (d) Action Plan development. COPE exercise helped the staff to identify their strengths and the problems they face in quality family planning and health services.

### **What have been done through the Systems Approach Project:**

1. Technical assistance has been provided to thana, Union and community level staff to make them aware about the clients rights, to identify the needs of the clients and to assess their problems in provision of quality family planning services for both male and female, clinical and non clinical.
2. Refresher training has been provided to all Sr.FWVs. and FWVs with emphasis on counseling and importance of male involvement in family planning.
3. All other clinical and non clinical field staff including SACMO, FPI, Pharmacist, FWA ,selected health staff (Health Assistants, Assistant Health Inspectors) and NGO supervisors have been oriented on contraceptives technology updates.
4. Three physicians (two GOB and one NGO) have been trained to perform voluntary sterilization procedures including Non-Scalpel Vasectomy.
5. To improve community support, especially to improve male participation in family planning seminars were arranged. A Member of the Parliament was involved in one of the seminars. In addition to the thana level, health and family planning staff members, the seminars were participated by the following:
  - a. Male house owners of satellite clinics, EPI Centers and cluster based injectable services points,
  - b. Union Parisad Chairmen and members,
  - c. Husband of family planning female staff,
  - d. FPIs and selected male staff of Health and NGOs,
6. District and thana level supervisors were trained in facilitative supervision techniques.

### **Results obtained so far:**

1. An evaluation of the project has recently been done by a group of highly professional people. The evaluation team was headed by Dr. John Stoeckel, an International family planning consultant. Members included among others the Project Director of Clinical Services of the Directorate of Family Planning. According to the evaluation report”.... there is a striking change in attitudes and behavior among service providers”. They were now more aware of and responsive to clients needs and rights, and paid increased attention to counseling, infection and client screening (Stoeckel, J. et al).

2. Though there is no dramatic change in the method mix in all the thanas, there has been an increasing trend in acceptance of male methods. The following tables shows the new Vasectomy users and monthly average Condom users in three thanas of Sylhet district during the last 18 months from October,1995 through March, 1997.

In Table-1, number of vasectomy procedures by thanas is shown. In each of the thanas vasectomy performance has increased. Though the numbers are not as expected, but it clearly indicates the beginning of changes. It needs to be mentioned here that vasectomy services are not yet regularly available in all the thanas. Because, there is no on site service provider in two of the three thanas. The service providers from other thanas or FPCST Consultants are made available to perform the procedures.

Table 1  
Vasectomy users

Name of thana	Oct,95- Mar,96	April-Sept.,96	Oct,96-Mar,97
Golapganj	3	6	2
Jaintapur	0	0	9
Zakiganj	3	9	25
TOTAL	6	15	36

Per latest report from Thana Family Planning Officer, Zakiganj 84 sterilizations has been performed during the period September 1996 through June, 1997, of them 42 were vasectomy. This needs to be mentioned here that in Zakiganj vasectomy performance had been almost nil before October, 1995. Again this thana is considered to be one of the most conservative areas of Bangladesh.

Table 2 shows the number of average monthly users of condom by thana during the eighteen months period from October, 1995 through March, 1997. This also shows an increased use rates in all the thanas during the six month period from October,96-March, 97 compared to October, 1995-March, 1996.

Table 2  
Condom Users

Name of Thana	Oct,95-Mar,96	April-Sept.,96	Oct,96-Mar,97
Golapganj	3512	3662	3806
Jaintapur	1196	1226	1391
Zakiganj	2410	2565	2555

3. Referral of clients from NGO to GOB facilities as well as coordination between them improved substantially(Stoeckel, J. et al).

#### **Problems related to male involvement:**

The problems related to male involvement as identified during the base line information collection and COPE exercises in three thanas of Sylhet are summarized below:

**(a). Lack of trained Service Providers**

1. In one of the three thanas, the position of MO(MCH-FP) has been vacant for long time. In two other thanas, MO(MCH-FP) were in position but none of them was trained in providing male sterilization services.
2. In the H&FWCs at Union level there is no family planning staff to educate , counsel and to provide services to male. In a Union there are three male staff, one FPI, one Medical Assistant (now redesignated as SACMO) and one Pharmacist. The FPIs are responsible for supervision of the grass root level workers(FWAs). The SACMOs and Pharmacist are not trained in providing family planning information , counseling and services. SACMOs remain busy mostly for curative services to the males, mothers and children coming to the centers for services. Pharmacist is responsible only for dispensing medicine. The Family Welfare Visitors posted in the H&FWCs provide services only to females, especially IUD and Injectable services.
3. Family Welfare Assistants (FWA) are the front line village based workers for family planning information and services. These female workers mostly deliver information and supplies to women at their homes. They seldom are in contact with the potential male users. Whereas a study suggests that the Bangladeshi male prefer to speak to family planning service providers prior to their decision to go for vasectomy (Faisel et al).

**(b). Lack of facilities for male services**

1. In the community level .satellite clinics and EPI spots are held for female and children. There is no provision for information, counseling and services to male from satellite clinics.
2. FWCs are known in the community as service centers for women and children. As such , men are reluctant to go to H&FWCs for family planning advice and services
3. In the grass root level, for many known reasons, FWAs approach is mainly to women on female methods, mostly , non clinical methods.

**(c). Information, Education and Communication(IEC)**

1. There are many misconception and rumors about family planning methods, especially the male methods, even among the health and family planning staff.
2. There has been no special IEC or any special initiative to update knowledge of family planning and health workers on contraceptive technology and to involve male in family planning.
3. Counseling for male are non existent at grass roots, community , Union and thana level. There is lack of method specific IEC or any initiative at field level in general to improve

participation of men in family planning in using methods, supporting wife to use a method, and even discussing among males on family planning.

#### **(d). Coordination of GOB, NGO and Private sector efforts**

NGO and private sector activities are not that strong except in one thana. But there is no coordinated innovative approaches for involvement of males in family planning.

#### **(e). Misconceptions**

The conservative culture, low literacy rate has created many superstitions and misconception among both the males and females. Religion is considered a barrier for acceptance of family planning. Early marriage is a normal scenario and there is a strong pressure from the seniors in the family to have the first child at an earliest.

#### **Strengths and opportunities for involving male:**

Both in the self assessment of staff and interview of clients during COPE , exercises, and baseline information collection, the following strengths and opportunities were identified:

1. The facilities for family planning services, including male services, are available at Thana Health Complexes.
2. There is demand for male services , particularly, for vasectomy services.
3. Male community leaders has been supportive to family planning programs, and they have been providing free accommodation for family planning satellite clinics, cluster based injectable services, EPI services and Jiggasa programs.
4. Most of the grass root level female health and family planning workers (Health Assistant and FWA )are local, and their husbands are educated and influential in the community.
5. Community leaders like Union Parisad chairmen and members, and thana level managers of other development agencies who are all males are supportive to family planning and MCH activities.

#### **LESSONS LEARNED AND FUTURE DIRECTION**

The lessons learned from the AVSC 's client-centered, clinic-based Systems Approach project are mentioned below. Many of these can be tried in the future:

1. Health and Family Planning service providers at the thana, Union and grassroots level (both GOB and NGO) need to be oriented on the importance of male involvement, and to dispel all misconceptions regarding use of male methods.
2. All levels of health and family planning service providers should receive intensive skills training on Inter Personal Communications(IPC) and counseling on addressing issues of males and getting them involved in reproductive health program.

3. The advantages of vasectomy, better use of condom to prevent transmission of RTI/STDs and effective participation of males in reproductive health issues need to be promoted through all means of IEC.
4. Presence of trained service providers at the Thana Health Complex and at Union Health and Family Welfare centers is very important for male involvement in family planning.
5. Community leaders, specially those who are already helping family planning and health program by providing free accommodation for satellite clinics, EPI spots, cluster services spots need to be recognized, oriented and used in creating a favorable atmosphere in conservative and low performing areas.
6. Provision should be made for services to male in the satellite clinics. May be separate satellite clinics for men at times convenient to them may be thought to improve male involvement and their access to services. The SACMOs may be assigned to arrange such satellite clinics.
7. Community people should know the type of services being provided from THC's, FWC's and satellite clinics. Signs on each of the services available for male and female in each of the service site is necessary. IEC activities for male participation in family planning and male responsibility in reproductive health need to be strengthened.
8. Modify job description of male staff(FPI, SACMO, Pharmacist, Health Assistant and Assistant Health Inspector) by adding their responsibilities to educate males and to provide services to them.
9. Arrange special day vasectomy services in each H&FWC at least once in three months.
10. Aware community people that family planning education and services for male are also available at H&FWCs.
11. Doctors from health services should be trained in vasectomy procedures from the thanas where there is no trained MO(MCH-FP).
12. Introduce recognition system for the thanas with highest vasectomy users.

## References

1. NIPORT, Mitra and associates, 1997, *Bangladesh Demographic and Health Survey, 1996-97, Dhaka*
2. NIPORT, *Bangladesh Fertility Survey, 1975.*

3. Haider, S.J.K. Strietfield and M,A. Karim.1995 “*Comprehensive Guidebook to the Bangladesh Family Planning-MCH Program*”. *Research Evaluationa Associates for Development, The Population Council, Ministry Of Health and Family Welfare, Government of Bangladesh.*
4. Rob, U.et al, 1996. *Male Involvement in Family Planning Program:Bangladesh.*
5. AVSC International, *Annual Report, 1996/97*
6. Schular R. Sidney et al, 1995 ,*Bangladesh’s Family Planning Success Story: A Gender Perspective, International Family Planning Perspectives, 21:132-137 & 166, 1995*
7. Faisel, A. J., Ward, V., Landry, E., Mehta, M. 1995. *Vasectomy Decision Making in Bangladesh, AVSC International*
8. Stoeckel, J et al. 1997. *Evaluation of the Bangladesh Systems Approach Project.*

## Introduction

Male involvement in FP-MCH-Reproductive Health Program is one of the most nagging issues facing reproductive health programs, service providers and donors. It became an agenda in the ICPD program of action and the signatory countries are committed to implement the agenda in their respective country program. In the recently designed National Integrated Population and Health Program (USAID, 1997), male involvement is one of the proposed strategies of increasing utilization of high impact essential health services package targeted for the families, both rural and urban. In this paper, we shall discuss the role of males, in particular the role of newly married husbands in the use of family planning methods in Bangladesh.

It is widely acknowledged that newlywed couples (those who are married within the last 12 months) are least served and recognized as a critical target group for family planning including other reproductive health services (Alauddin and VanLandingham, 1989). The national family planning program has explicitly committed to provide special focus to improve service coverage for them. There are compelling reasons to give such attention to the newlywed couples as a critical target group.

First, their size is large; 1.32 million newlywed couples are added each year to the pool of eligible couples for family planning services (BBS, 1995).

Second, most of the newlywed women are in their adolescent ages, below 20. Adolescent fertility rates are higher in Bangladesh than in many other countries - more than one-fifth of adolescents give births by age 15, and two-thirds by age 18 (Safe Motherhood in South Asia, 1990).

Third, the adolescent mothers are at high risk for maternal mortality and morbidity. The children they bear are also at high risk. The maternal mortality rate for those women who are below 20 is 8.6 per 1000 live births, which is much higher than the already very high maternal mortality rate, 5.7 per 1000 live births for all women, in Bangladesh (Alauddin, 1986). Also, data from four Thanas of Jessore and Serajganj districts provide evidence that foetal loss, neonatal and infants deaths are more among these mothers (Nessa, 1993).

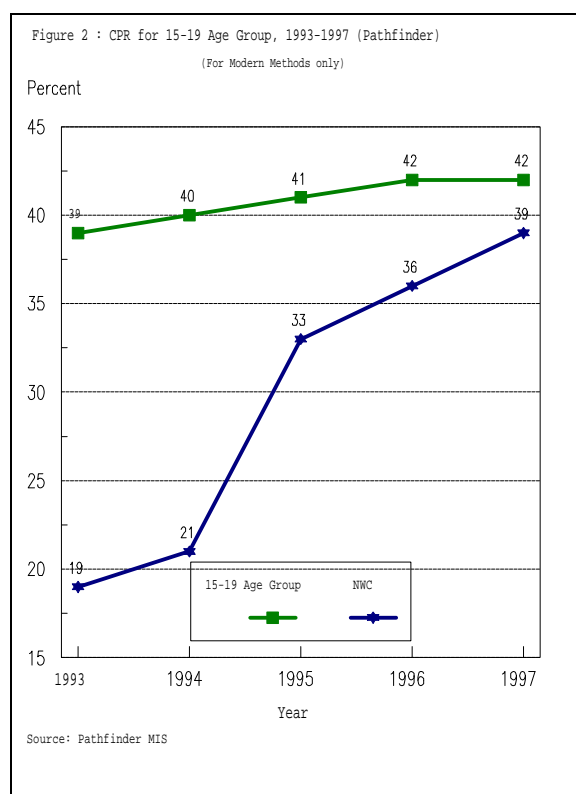
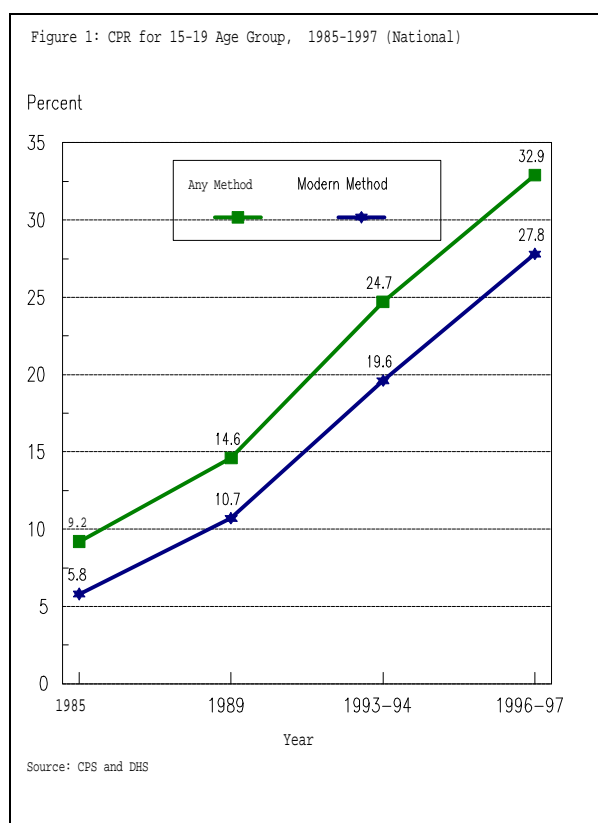
Fourth, one can conclusively say that unmet demands exist for family planning among newlywed couples. Contrary to traditional notions, recent striking changes in couples' attitudes about the desired number of children signal that Bangladeshi young couples are highly receptive to the concept of the small family. Their desired family size is close to the 2-child family which is the goal of the national family planning program.

Fifth, most of all, they are willing to adopt appropriate behavior for small family and contribute to the country's goal of reduced fertility and improved health. Their desire for achieving small family is reflected in their actual behavior - in the use of family planning methods.

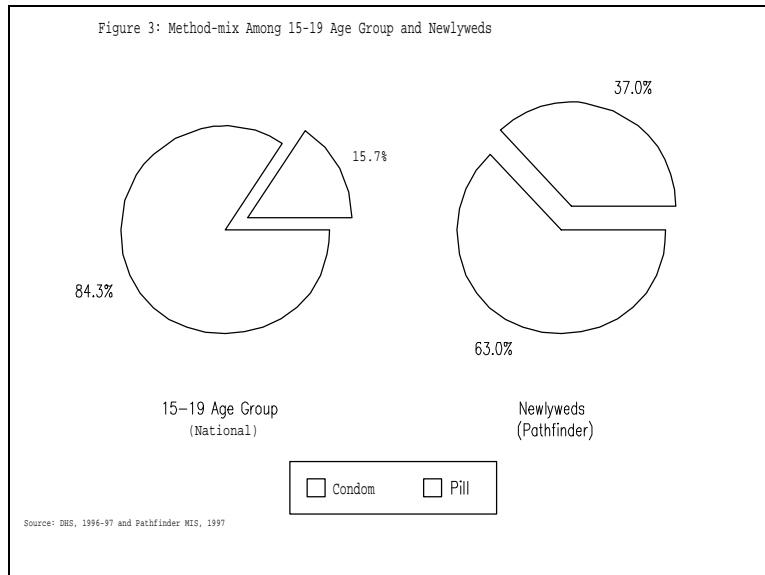
## Increasing Trend in CPR

As we can see from the following graphs, the contraceptive use among the young couples who are less than 20 and most of whom are newlywed couples, for the country as a whole, is on the increase - the CPR has increased more than three times, from 9.2 percent to 32.9 percent for any methods, and from 5.8 percent to 27.8 percent for modern methods during the last ten/twelve years - between 1985 and 1997 (CPSs 1985, 1989 and DHSs 1994, 1997).

Similar trend is observed in the NGO-served areas. Data are available for the period, 1993-1997. The current CPR for modern methods among the young women who are less than 20 and most of whom are newlywed couples has risen from 39 in 1993 to 42 percent in 1997. Specifically, the CPR for the newlywed couples has doubled, from 19 to 39 percent during the last five years, 1993 - 1997 (Pathfinder MIS, 1997).



## What roles the husbands play in the increase in use of family planning methods among the newlywed couples?



To explore the answer for this question, we would like to find out whether husbands themselves undertook the responsibility of using contraceptives. According to the most recent DHS (1996-1997) data, 16 percent of the newlywed husbands used condom, the remainder 86 percent of their wives used pills. It is interesting to note that rate of condom use among the young couples is 4 percentage point higher than the total national rate of condom use. It suggests that husbands of younger generation may be more likely to take-on contraceptive practice responsibility compared to the husbands of older

generation. According to Pathfinder MIS, as is seen in figure 3, the rate of condom use among the newlywed couples is 37 percent - two times higher than the national rate.

With regard to the question of who obtained the supply of condom, it is safe to assume that husbands themselves obtained the supply of condom. In a Bangladeshi cultural where it is common for the husband or another male relative to go to a drug seller, doctor or clinic to obtain medicine for their wives (Schuler, et al. 1997), it is reasonable to assume that husband has taken the role of obtaining pills for their wives contraception. This assumption is substantiated by findings of a recent study (PDEU, 1997) that husbands bought Pills for the 50 percent of wives who were taking oral contraceptives.

There are other evidence that husbands buy/procure pills for their wives. One of our largest rural project introduced depot-holding system - where clients are encouraged to take their supplies from the depot-holders' houses. Currently 20 percent of the pill and condom users are collecting their supplies from the depot-holders' house. Of those who collected supplies from depot-holders' house, 40 percent are males (Pathfinder MIS, 1997).

Islam et al (1995) from their study of "Fertility and Reproductive Health Status of Married Adolescents in Rural Bangladesh" reported that 41 of the users (male or female not specified) procured their supply from source other than the fieldworker - hospital/health center (18.1 percent) and shop/pharmacy (22.5 percent).

Some of the husbands are motivators as well. According to Islam et al (1995), 45 percent of the contraceptive users were motivated by their husband. A study on pill users (PDEU, 1997) reported that nearly one-fifth of the pill users were motivated by their husbands.

With regard timing of contraception, at least one-fourth of the users are reported to have initiated contraceptive use soon after their marriage, and another 27.6 percent within one-two year of their marriage (Islam, et al. 1995). Drawing data from 7 sites, FDSR found 43.5 percent newlywed couples as users of family planning - more than half of the users (57 percent) are condom users; 71 percent of the users started using method within one month of their marriage.

NGO service statistics reported higher rate of CPR among the newlywed couples, even higher is the rate of condom use - twice as much as the national rate. What are the interventions NGOs employed in increasing contraceptive use among the newlywed couples in general and in use of condom in particular and whether and how the role of husbands are enhanced?

## **Interventions**

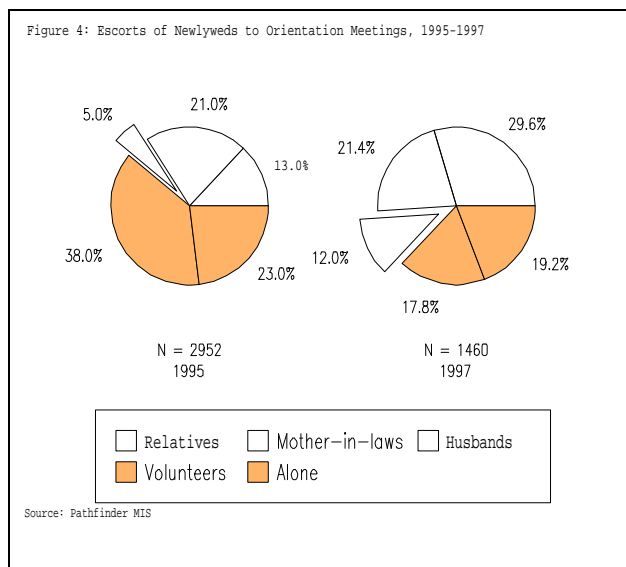
The focused attention to the newlywed couples began in 1993 with a National Reception to the Newlywed Couples held in Dhaka jointly organized by the Ministry of Health and Family Welfare and the Pathfinder International. The theme of the year was: Newlyweds should not become pregnant before they are 20, and prematurely become old at 20 (translation of a Bengali proverb). Sixty four couples - one from each district attended the reception. Similar receptions were held at the thana and union level as well. The reception activity is continuing in the NGO projects.

Following the reception, 29 NGO projects, with funding and technical assistance from Pathfinder International, started developing a service delivery approach to improve coverage for newlywed couples.

**Identification and registration** of the newly married couples were the beginning task to reach the newlyweds. Every marriage held in the assigned geographic area of a fieldworker were registered within 4-6 weeks during her routine daily visits. Almost all of the staff (94 percent) of the USAID CA-funded NGOs reported in a study that identification and registration of the newlywed couples are done in their projects (Chowdhury, et al 1996). Registration of the newlywed couples provides the family planning fieldworker an opportunity to introduce herself to the couple and to establish relationship with the bride's family and thus set the stage for offering services subsequently.

**Family planning and MCH services are provided to the newlywed couples.** The fieldworkers provide supplies of contraceptives to the newlywed couples who want to use them. Should the brides become pregnant, the family planning workers advise them on pregnancy care, and safe delivery. During postnatal period, family planning workers encourage the mothers to breastfeed, arrange immunization for the newborn and provide appropriate contraceptive services and supplies for spacing for the next pregnancy.

Besides one-to-one basis education and counseling, **the newlywed couples are invited to family planning and MCH orientation meetings.**

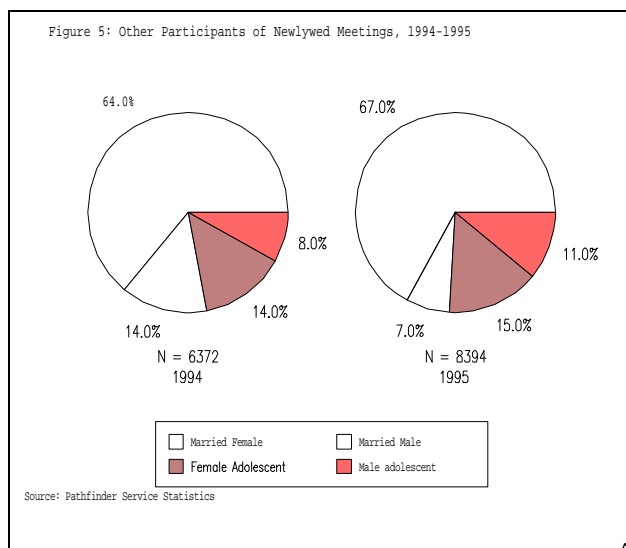


Such meetings are held mostly at the private houses in the community. The purposes of such meetings are to orient the newlywed couples about population problems of the country, explain the risk of early pregnancy and benefits of delaying the first pregnancy and advantage of keeping a family size small, tell them what are the MCH services and family planning methods available and from where they could get them.

IEC materials (field guide, family planning calendar) are used in such meetings. On the average 8 to 10 wives attend such meetings. Orientation meetings are even held in conservative areas like Noakhali and Sreemangal. Both husband and wife rather than wife alone are invited to orientation meeting.

Recently the fieldworkers are giving more emphasis to ensure husbands' participation. NGOs keep track of who attend these meetings. Generally newlywed brides attend the meeting accompanied with in-laws or others. Husbands' attendance is very low. However, their attendance is increasing. The figure 4 shows that in 1995, only 5 percent of the husbands accompanied their wives to the orientation meetings; in 1997 the attendance rate for husbands rose to 12 percent. A remarkable social change, however, is observed that one-fifth of the wives come to attend meetings all by themselves, not accompanied by any one, another one-fifth are accompanied by their mother-in-laws. The remainders are accompanied by other in-laws and volunteers.

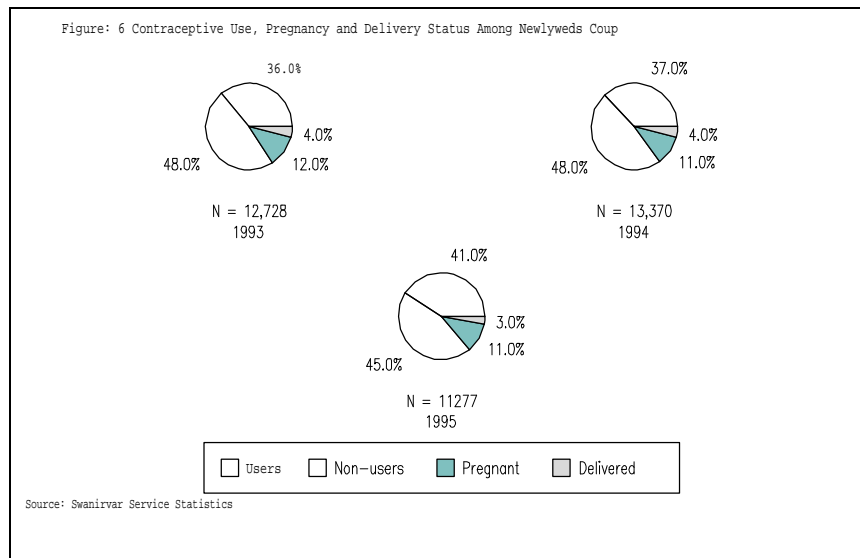
An striking feature of the orientation meeting is the attendance of the unmarried male and female adolescents - their share is 11 percent and 15 percent, respectively.



Participation of adolescents in such meetings where reproductive health issues are discussed will prepare them better to be more responsible even before entering into the conjugal life. Other male attendance include Union Parisad chairmen and members. Newlywed orientation meetings are held at the private houses in the community. Such community involvement is crucial for the success of a sustainable service delivery including behavior change communication services in rural areas.

As is seen in Figure 6, during 1993-95, 36 to 41 percent of the newlywed couples have been

using family planning methods. Eleven to twelve percent of the newlywed couples have become pregnant and another three to four percent gave births. If these 36 to 41 percent of the couples did not use family planning methods, undoubtedly the pregnancy rate would have been significantly higher than the present rate. The present pregnancy rate -- 11 to 12 percent, among the newlywed couples for the NGO-served areas is lower than the national rate of pregnancy, which is 17.1 percent, for the age group 15-19 years.



## Discussion

Husbands, who are generally older by 7 to 8 years than their new brides, in some cases take lead roles in the use of family planning methods. They themselves are **users** of condom, although at a much lower level than their spouses. There seems to be an increasing trend for the newly married husband to be users of condom.

Husbands are **motivators** for their wives contraception and **buyers** of contraceptives for their wives; they are also a **source of knowledge** for some wives on when to start taking oral contraceptives.

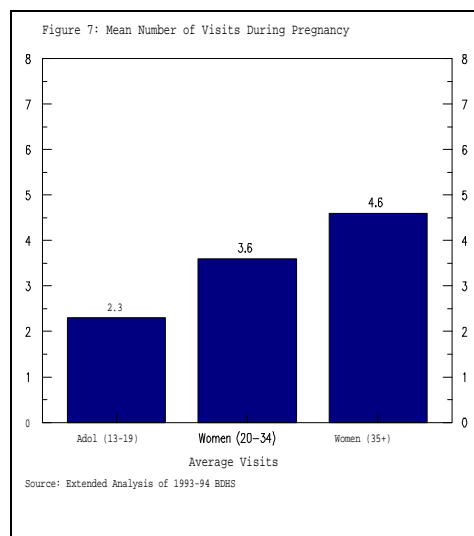
Although their numbers are increasing in attendance of orientation meetings organized for the newlywed couples, husbands participation is poor. One of the reasons, is the timing of the meeting. The orientation meetings are held at the prime working hours of the day when husbands are out at work, and perhaps cannot afford to abse nt themselves from the work.

The newlywed couples' intention to use contraceptives is very high, but perceived lack of familial and social support hold them back from contraception: There is a very high level of intention of future use of family planning. Of those who never used family planning, 65 percent intend to use in the future. And there is near universal support (92 percent) for family planning use among the adolescents (Islam et al, 1995).

Familial and social barriers perceived by the newlywed couples constrain their use of family planning. Almost all adolescents (94 percent) perceive that their family members do not have favorable attitude towards married adolescents contraceptive use (Islam et al, 1995). Creating social support for newlywed couples is very important. Specially husbands' and mother-in-laws' support is very crucial. Attendance of in-laws, married males and females, unmarried adolescent boys and girls is likely to have major impact in removing perceived familial and social constraints.

Providers of health and family planning services themselves are barriers to improved coverage of males with services. There is a large number of male providers in the health and family planning sector - both government and NGOs, as well as private sector (Alauddin and Zaman, 1996). But they miss many opportunities and do not fully exploit the potential of serving males.

Along with family planning, husbands role in broader reproductive health is important. For example, adolescent mothers have fewer ante-natal check-ups during nine months of pregnancy. As is seen in the figure 7, pregnant adolescents received only 2.3 visits compared to 3.6 and 4.6 visits of women aged 20-34 and 35 plus. Also adolescents has to wait an average of 5 months for their first ante-natal contact while the other two age groups of women wait 4.5 and 3.6 months, respectively (NIPORT, 1996).



Not enough is known about the decision making process of the newlywed couples. The efforts and the interventions that have been employed show increasing trend in contraceptive use among newly married couples. But still there is much room for further improvement. We do not have enough understanding of the determinants of newlywed couples' decision-making process for contraception and other reproductive health seeking behavior. This could be one potential area of operations research to contribute in formulating strategies and program intervention for the newlywed couples.

## Conclusion

Empowering women in different socio-economic aspects of life is an important development agenda in Bangladesh. While it is important to increase male's role in improving family health, we should not do any thing antithetical to women's empowering process. It is very interesting to note that 44 percent of the adolescent wives who are users of family planning methods are self- motivated. That means these young women seem empowered in health seeking behavior. We should aim for a balanced role of husband and wife in seeking family health services so that we have achieved reduced fertility and improved health.

## References:

- Alauddin, M. and Mark VanLandingham. 1989. "Young, Low-parity Women: Critical Target Group for Family Planning in Bangladesh". *Asia-Pacific Population Journal*. 4(1):49-58.
- Alauddin, M. 1986. "Maternal Mortality in Rural Bangladesh: The Tangail District". *Studies in Family Planning* 17(1): 13-22.
- Alauddin, M. and AKM Rafiq-uz-Zaman, 1996. "Males as FP-MCH-RH Service Providers". A paper presented at the seminar on "Male Involvement in Family Planning: A Challenge for the National Program". Dhaka.
- BBS, 1995, *Statistical Year Book of Bangladesh for 1995*, Fifth Edition, Ministry of Planning, Dhaka, December.
- Chowdhury, A.Y. et al. 1996. *Operations Research on NGO Efforts to increase contraceptive use among newlywed and low parity couples*. PIACT, Dhaka.
- DHS, 1996-97, *Preliminary Report, NIPORT*, Dhaka, Mitra and Associates, Dhaka and Macro International Inc., Calverton, Maryland.
- Islam, Nurul. et al. 1995. *Fertility and Reproductive Health Status of Married Adolescents in Rural Bangladesh*. PDEU, Dhaka.
- Nessa, Fazilatun. 1993. "Fertility Behaviour and Pregnancy Outcome Among Rural Adolescent Women in Bangladesh". Program and Abstract. Second Annual Scientific Conference. January 16-18, Dhaka: ICDDR,B.
- NIPORT and The East-West Center, 1996. *Extended Analysis of the 1993/94 Bangladesh Demographic and Health Survey*.
- PDEU, 1997, "Oral Contraceptive Compliance: A KAP Baseline in Rural Bangladesh", Ministry of Planning, Government of Bangladesh.
- Pathfinder MIS, 1997. *Annual Reports, 1993-1996*.
- Safe Motherhood in South Asia, 1990. "Women's Lives in South Asia". The South Asia Safe Motherhood Conference, Lahore, March 24-28.
- Schuler, Sidney and Zakir Hossain, 1997. "Family Planning Clinics Through Women's Eyes and Voices: A Case Study from Rural Bangladesh". JSI Working Paper, Virginia.
- USAID, 1996. *The National Integrated Population and Health Program (NIPHP), Design Workshop*, October 13-24, 1996, Rajendrapur.

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August 18, 1997

Mr. M. Nawab Ali  
Coordinator, MIP  
The Population Council  
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Dear Mr. Ali:

Please find herewith a revised copy of the paper "Newlywed Couples: Role of Husband in Use of Family Planning" presented at the Workshop on Male Involvement in Family Planning: Experience from Innovative Approaches held on August 7, 1997 at Rajendrapur. Please call Toslim Khan if you need anything more in this regard.

With best regards,

M. Alauddin, PhD  
Country Representative